ACCESSIBILITY AND EFFECTIVENESS OF ANTI-HUNGER PROGRAMS

HEARINGS

BEFORE THE

SELECT COMMITTEE ON HUNGER
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

HEARINGS HELD IN GREENWOOD, MS, JUNE 25 AND
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ACCESSIBILITY AND EFFECTIVENESS OF ANTI-HUNGER PROGRAMS

MONDAY, JUNE 25, 1984

House of Representatives,
Select Committee on Hunger,
Greenwood, MS.

The committee met, pursuant to call, at 12:30 p.m., in the Greenwood-Leflore Civic Center, Greenwood, MS, Hon. Mickey Leland (chairman of the committee) presiding.

Members present: Representatives Panetta, Fazio, Roukema, Emerson, Morrison, and Smith.

Also present: Representative Franklin.

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

The Chairman. We are going to begin this hearing of the Select Committee on Hunger. We are under severe time constraints, so we are going to start as quickly as possible in order to give our witnesses time to complete their testimonies.

I want to welcome all of you here and thank the city of Greenwood for the contributions you have made to the committee and the organization of this hearing.

I am Congressman Mickey Leland, chairman of the House Select Committee on Hunger. With me are Representative Leon Panetta, the chairman of our Domestic Task Force on Hunger in the United States; Representative Vic Fazio; Representative Marge Roukema, ranking minority member of the committee; Representative Bill Emerson, ranking minority member on the Domestic Task Force on Hunger; Representative Sid Morrison and Representative Robert Smith.

Sitting with the committee today is Representative Webb Franklin, who represents the city of Greenwood in Congress, and we are pleased to be here in Webb's town.

We are here to discuss how hunger can be alleviated in Leflore County and to see how Federal antihunger programs can be made more effective. This committee initiated this hearing because it wanted to find constructive solutions. After we informed people of our plans, we received valuable assistance from a great many members of this community of all political persuasions. I want to take this opportunity to thank all of you for that assistance.

Earlier today we were able to visit with citizens of the community. We learned firsthand of their personal experience with hunger and with assistance programs. Although I have been working on the hunger problem for many years, I cannot get used to hunger and desperate poverty in our plentiful land. There is no reason for it, there is no excuse for it, and it is time that we as a nation, put an end to it. [Applause.]

I appreciate the applause. However, we must proceed if we are to complete our hearing in the time that we have.

The problems of poor people in Leflore County are complex and intertwined. Low Aid to Dependent Children benefit levels, inadequate food stamps, and the lack of economic opportunity are all forcing mothers to decide whether to buy enough food for their children, pay the utility bill, or buy clothes for their children. Fifteen percent of Americans, over 34 million people, live below the poverty line and face similar cruel choices.

Many people will be impressed to hear that, in 1983, the Federal Government spent $19 billion to fund food assistance programs. Well, I am personally not impressed that the Government manages to spend 2 percent of its budget to reduce hunger. I am, however, impressed by the urgency of dealing with hunger and the problem of extreme poverty which still exists.

It is true that great strides have been made in Mississippi in the struggle against hunger but there is a long way to go. Here in Leflore County, as in many areas of the United States, poverty and deprivation are still killing children. The infant mortality rate among black children in Leflore County—which stands at approximately 31 deaths per thousand—is higher than in most less developed nations in the Caribbean.

In Leflore County and throughout the Nation we must set ourselves to eliminate hunger and life-threatening poverty. It should not be our purpose to engage in sterile debates, but rather to move forward with the aim of producing results. Lower infant mortality, reduced incidence of low birth weight, a healthy, well-nourished, productive population, these are our goals. We need to find practical, realistic ways to attain these goals. It is my hope that working together, today and from now on, we can take a step forward in this endeavor.

I would like now to introduce to you and ask if she will give her statement, the ranking minority member of this committee, Representative Roukema.

Marge.

OPENING STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mrs. ROUKEMA. Thank you, Mr. Chairman. I am Congresswoman Marge Roukema from New Jersey and it is my pleasure, ladies and gentlemen, to be with you today.

Mr. Chairman, I ask unanimous consent that the full content of my remarks be entered into the record.

The CHAIRMAN. Without objection.

Mrs. ROUKEMA. I would like, however, to make a few observations today.

I would first like to thank my colleague, and hardworking colleague at that, Congressman Webb Franklin. It was his invitation that helped to confirm the intention of this committee to conduct our first important hearing here in Greenwood. His staff has provided invaluable assistance to both individual members and the committee as a whole and helped to prepare us for this formal hearing.

Mr. Franklin's cooperation has been complete and should be recognized as such and his help has led toward a comprehensive and balanced study of the program.

I personally have come here to learn firsthand about the poverty and hunger that exists here. It is obvious that somehow all the programs provided by the Federal Government are not completely accomplishing what was originally hoped for them. Although the statistics indicate that the trend is upward in terms of solving problems of hunger and poverty, we are a long way from accomplishing our goals.

There is more work to be done and that is why the committee is here. There are basic questions that are crying out for answers. Are there programs that are not reaching those that are eligible? Are there laws or regulations that hinder implementation of these aid programs? Have we overlooked the unique needs of the rural areas such as Leflore County when we crafted assistance programs? Are there underlying socioeconomic trends that undermine the progress and the goals that we have set forth?

These are the questions. Hunger and poverty are endemic. How can we break the vicious cycle?

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Roukema appears at the conclusion of the hearing, see p. 185.]

The CHAIRMAN. Thank you, Congresswoman.

We now are going to ask the mayor of Greenwood to make a brief statement.

Mr. Mayor.

STATEMENT OF LANIER HARPER, MAYOR, GREENWOOD, MS

Mr. HARPER. Thank you, Mr. Chairman, Congressmen and Congresslady. We appreciate your being here in the city of Greenwood. In front of you I have placed a—Greenwood had their sesquicentennial, their 150th anniversary and there is a plate here and a book on the history of Greenwood, a little word from me, a chart.

Before you leave, I would like to say,

> When things go wrong, as they sometimes will, when the road you're trudging seems all uphill, when the funds are low and the debts are high and you want to smile but you have to sigh, when cares are pressing you down a bit, rest if you must but don't you quit. Life is queer with its twists and turns, as everyone of us sometimes learns and many a failure turns about when he might have won that he stuck it out. Don't give up though the pace seems slow, we may succeed with another blow. Often the goal is nearer than it seems to a faint and faltering man. Often the struggler has given up when he might have captured the victor's cup and he learned too late when the night slipped down how close he was to the golden crown. Success is a failure turned inside out, the silver tint of the clouds in doubt and you can never tell how close you are, it may be near when it seems so far. So stick to the fight when you're hardest hit, it's when things get worse that you mustn't quit.

The author is unknown but keep working on our problems here. Thank you.

The CHAIRMAN. Thank you very much, Mr. Mayor. We really appreciate your kind words and we need your words of inspiration and all the help you can give us. We thank you and all the beautiful people here in Greenwood and Leflore County. You have all been absolutely magnificent.

I would like now to turn over the gavel to my colleague from California, Leon Panetta, the chairman of the Domestic Task Force on Hunger in the United States.

Leon.

OPENING STATEMENT OF HON. LEON E. PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Panetta**. Thank you, Mr. Chairman. It is a pleasure to be here in Greenwood and to have so many people who are interested in following the hearings. This is one of the bigger crowds that we have had.

The subcommittee that Bill Emerson and I chair on the Agriculture Committee that deals with nutrition has gone throughout the country in Birmingham, Cleveland, Chicago, Miami, Los Angeles, and now we are visiting rural areas such as Greenwood. I might say that in the time we have had those hearings, I think this is one of the largest crowds we have had turn out for a hearing and we thank you for that because you are interested in the problems we are looking at.

I am Leon Panetta. I am a Congressman from California and have the honor of chairing the Domestic Task Force on Hunger for the Select Committee on Hunger, as well, as I indicated, the Nutrition Subcommittee of the House Agriculture Committee.

Why are we here? Seventeen years ago in June 1967, a team of physicians testified before a Senate subcommittee what they found in their recent visits to poor families in the Mississippi Delta. They stated, and I quote, at that time,

> In sum, we saw children who are hungry and who are sick, children for whom hunger is a daily fact of life and sickness, in many forms, an inevitability. The boys and girls we saw were hungry. They were weak, in pain and sick. Their lives are being shortened. They are visibly and predictably losing their health, their energy and their spirits.

Today this committee is back again examining the nutritional status of the poor in rural Mississippi. What we found is that largely due to the expansion and improvement of many Federal programs, conditions have obviously improved since 1967. The facts are that there remains at this time a significant problem of malnutrition and undernutrition.

The committee has come here to take a balanced look at all the conditions in Leflore County. No doubt, we cannot learn everything in 1 day. I do not think we can. We tried to plan our day so that we could look at all the relevant facts, conditions, and viewpoints that can be presented to us. We need and want the full story.

The story that we see here is very similar to the story that we see in many other areas. There is a concern about the growing needs for the hungry in our society. I don't think the question anymore is whether or not hunger exists, the question is what are we going to do about it?

To respond to the hunger problem, Representative Emerson and I, along with others, have introduced a bill into Congress, H.R. 5151, which is called the Hunger Relief Act of 1984. Hopefully it will come to the floor of the House within the next few weeks. That bill is aimed at providing additional benefits, increasing work incentives, and improving nutritional services for our most vulnerable citizens. The hope is that we can get this legislation passed not only by the House, but by the Senate, and get it adopted in trying to respond to the problems that we are seeing throughout the country.

In closing, I want to thank all of the people here of Leflore County, I want to thank the Congressman from the area for the help and cooperation he has provided to us. I know that there are many local people who are interested and concerned about this problem and I hope that your hard work will pay off and that our hard work will pay off as well.

Mr. Emerson.

OPENING STATEMENT OF HON. BILL EMERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. EMERSON. Thank you, Mr. Chairman.

I am pleased to be here in Leflore County and in Greenwood for the first hearing held by the Domestic Task Force of the Select Committee on Hunger. I want to express my thanks and I am sure the thanks of all of us to Congressman Franklin for his invitation and for his willingness to assist this select committee in planning this hearing. Congressman Franklin has made his office and his staff available to all members and staff of this committee and I am confident that without this aid that we could not have had such a successful day as we have had and are having.

As some of you may know, the Select Committee on Hunger was established earlier this year by the House of Representatives to review the issue of hunger here and abroad and to make recommendations to the standing committees as to any legislative changes that are warranted. Chairman Panetta and I both served in these same capacities, chairman and ranking Republican on the subcommittee with jurisdiction over several food assistance programs, one of which is the Food Stamp Program. We have held hearings this year and last year across the United States reviewing this same issue.

As a result of the subcommittee's activities, as Chairman Panetta mentioned, H.R. 5151, the Hunger Relief Act of 1984, will be taken to the House floor in the near future. Chairman Panetta commented on this bill and I am sure it is his modesty as the chairman of the subcommittee and the chief author of the bill that he didn't tell you some of the very good things that I think this bill accomplishes and so I want to take this opportunity to make a couple of points.

One, it increases the food stamp benefits in 1985 and 1986, and requires an indepth review of the Thrifty Food Plan, the basis for food stamp benefits. Two, it assures the homeless who are eligible for food stamps benefits that they can have access to the program. Three, it requires the States to assess the hours of operation of food stamp offices to insure that the working poor have access to the program and don't have to adjust their work hours in order to see about getting food stamps.

Four, it increases the work expense deduction from 18 to 20 percent of earnings and increases the shelter-dependent care deduction from $125 a month to $155 a month. Five, it improves the job search provisions of the Food Stamp Program by giving States broader flexibility to design job programs in which individuals can get jobs and can keep jobs. And six, it improves program accountability by increasing penalties for those States not reducing their rate of error to 5 percent. Increased penalties will be collected in 1987.

These are some of the provisions of this bill which were designed to address the needs of individuals relying on the program and to make the program more effective and efficient and I commend Chairman Panetta for his work on this bill and I enthusiastically support it.

As we begin our hearing today, it is my belief that many of the problems we saw this morning and the testimony that we receive this afternoon will reinforce the need to see H.R. 5151 pass. One day cannot give us a clear picture of what is going on in Greenwood, MS. That is why we must rely on both the witnesses we will hear from today and the experience gathered from our earlier hearings.

We do know what is available from the Federal Government to help the needy. The Food Stamp Program issued benefits totally $271 million in 1983 in Mississippi, $73 million more in benefits than were issued just a few years ago. Child nutrition programs, school lunch, school breakfast, special milk programs, child care food programs provided benefits of $89 million last year and WIC benefits totaled $26 million up from $16 million in 1980. Elderly feeding programs provided $1.6 million and almost $12 million of surplus commodities were distributed last year in Mississippi.

In addition, according to a publication Giving USA, Americans donated an estimated $60.39 billion to hundreds of thousands of charitable organizations, institutions, and agencies, some of which provided food to needy people both here in Mississippi and across the country. States and local governments also provided assistance for the needy through the Aid to Dependent Children and Medicaid Programs, which have shared funding with the Federal Government, emergency assistance, general relief assistance, and other local and State assistance programs.

Many Governors have set up a structure to assist the hunger situation within his or her State and I will be interested in hearing the Mississippi Governor's actions in this regard.

My point in briefly reviewing the programs available is to let you know that we are here to learn about Mississippi and Leflore County. If these programs are not working we need to know about it. If the benefits are not adequate we need to know. If housing is substandard we need to know. If medical assistance is not sufficient we need to know. However, you need to know that solutions do not—that all of the solutions do not rest with the Federal Government. Many issues must be resolved at the State and local level.

I believe that some of the solutions so far as they relate to Federal programs will be found in H.R. 5151. I am anxious to hear from our witnesses this afternoon and to hear in particular what they propose should be done.

Thank you, Mr. Chairman.

Mr. **Panetta**. Thank you, Congressman Emerson. We are on a very tight timeframe, so I would like to, if I can, limit the other congressional comments to a couple of minutes so we can get to our witnesses.

Congressman Fazio.

OPENING STATEMENT OF HON. VIC FAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Fazio**. Mr. Chairman, I have no statement to make at this time, but I would like to have the witnesses concentrate on one thing which I think is particularly clear to us after having had a rather brief exposure to the problems in this county this morning. How do we in practical every day terms make sure that the people who are currently qualified for benefits attain them? We see in the Food Stamp Program that 1 out of 3 potential beneficiaries essentially is not getting the benefits already due them. So what we need from you is some help as to how we can make the program already in place work for all the people who are eligible.

Thank you.

Mr. **Panetta**. Congressman Morrison.

OPENING STATEMENT OF HON. SID MORRISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. **Morrison**. Mr. Chairman, I would just like to add appreciation to the people we visited with this morning and to Webb Franklin and his staff for the books that he prepared so that we would have a glimpse at some of the programs that are here, some that are working and some that need some additional help. Again, we have met some beautiful people this morning and we look forward to hearing from all of you.

We know there isn't time for everyone to testify, but through the panels to learn more about the problems and opportunities that exist here and then be part of a Congress that will react and reach out a hand to help all Americans.

Thank you.

Mr. **Panetta**. Congressman Smith.

OPENING STATEMENT OF HON. ROBERT F. (BOB) SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. **Smith**. Thank you, Mr. Chairman.

I am here from Oregon and I am here to listen and learn and following your advice, Mr. Chairman, I will yield my time to my friend, Congressman Franklin.

Mr. **Panetta**. Congressman Franklin.

OPENING STATEMENT OF HON. WEBB FRANKLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. **Franklin**. Thank you very much, Mr. Chairman. I want to, on behalf of the people of Leflore County of the Second Congressional District of Mississippi, welcome this distinguished group of my colleagues to our community to look into a very serious problem that I think we have seen a little bit about in the brief time we spent in our home visits this morning.

Mr. Chairman, I thought long and hard about what to say to this distinguished group when you visited Greenwood. I believe I have examined the subject of hunger and food assistance in this State in a pretty exhaustive manner and quite frankly, I have examined and reexamined my own viewpoint on this subject over and over again in the recent months. I do not doubt that there are people in Greenwood, MS, and throughout this Nation who do not get enough to eat. In fact, we saw that today in our home visits. I have never doubted that.

This morning we went to the homes of some of these individuals and in the worst cases we saw living conditions which absolutely cannot be described. It is disgraceful and it does not—and it does demand the attention of this community and of this Government, but hunger is a complex problem and one that can only be understood in my opinion in a much larger context.

Mr. Chairman, I have studied the Federal Government's commitment to making food assistance available in Leflore County alone. That commitment is there and it is astonishing. Because of that Federal commitment, we provide free lunches to more than 80 percent of the schoolchildren in this county. Because of that commitment, we provide food stamps to more than one-fourth of this county's population. Because of that commitment, we have households which receive as much as $970 per month in food stamps alone. These totals have not gone down, Mr. Chairman, they have risen steadily in Mississippi over the last 20 years——

VOICE FROM AUDIENCE. No, no.

Mr. FRANKLIN [continuing]. And they are higher now than they ever were before.

VOICE FROM AUDIENCE. That is not true.

Mr. FRANKLIN. In cases I have personally in this—seen in this community, Mr. Chairman, encompass a broad, broad range of social problems. There are problems that are——

VOICE FROM AUDIENCE. No, no; that is not true.

Mr. PANETTA. Let us let everyone have their say and we are going to let all the witnesses have their say, but please we are on limited time and we are here to hear all of the information that is available.

VOICE FROM AUDIENCE. Mr. Chairman, we do not want him fabricating the situation. We want the truth.

Mr. PANETTA. The gentleman has a right to say his piece. Congressman Franklin, go ahead.

Mr. FRANKLIN. Thank you, Mr. Chairman.

The cases I have seen personally in this community, Mr. Chairman, encompass a broad range of social problems. There are problems of awareness, of people simply not knowing the vast range of Government assistance available to them. There are problems of education, of people simply unable to cope with the administration of the funds that are available to them. There are problems in housing, people living in $150 a month shacks, paying $200 a month in utility bills and we saw problems of chronic unemployment, a situation that can only improve in my opinion when Mississippi's negative image is finally overcome.

I have prepared a detailed report on this subject for submission to this committee. That report is my own individual attempt to define the problems that do confront us and I hope it may be of some value to this committee.

Mr. Chairman, I have also invited a number of the civic and religious leaders in this community to be here with us today. In fact, my staff wrote every religious organization and every civic organization in this county and obviously from the response that I see here with the people here, these people have responded.

I hope that from this meeting we as individuals and we as a community might examine the problems around us and might examine ways in which we all may better address those problems.

Thank you very much, Mr. Chairman, and again welcome to Mississippi.

Mr. PANETTA. Thank you, Congressman.

For the other members of the panel, their statements, if they have full statements, will be made part of the record without any objection.

We are going to proceed to our first panel of State and local administrators. They are the following: Beverly Hogan is executive director of Federal-State programs of the office of the Governor of the State of Mississippi; accompanied by John A. Frazier, who is deputy commissioner of client/field services, department of public welfare; Michael Raff who is director of the department of human development for the office of the Governor; the Honorable Alex Sanders who is on the Leflore County Board of Supervisors; Chris Murphree who is food assistance supervisor, Leflore County Welfare Department; and Mr. John Barr, who is director of the Mississippi WIC Program, Women, Infants and Children's Program, Mississippi State Board of Health.

Ladies and gentlemen, what I would ask you to do is if you could keep your statement to 5 minutes so that we would have an opportunity to ask some questions and be able to hear all of our panels today.

We will begin with Beverly Hogan who is executive director for the Federal-State programs, office of the Governor.

STATEMENT OF BEVERLY W. HOGAN, EXECUTIVE DIRECTOR, GOVERNOR'S OFFICE OF FEDERAL-STATE PROGRAMS, STATE OF MISSISSIPPI

Ms. HOGAN. Thank you, Congressman Panetta.

Mr. PANETTA. If you can get close to your mike it is possible that would be helpful.

Ms. HOGAN. Thank you very much.

To the members of the U.S. House Select Committee on Hunger——

Mr. PANETTA. I am sorry, it is not on. Can we get—you can use this mike.

Ms. HOGAN. I think the plug has been pulled, you might want to check that.

Thank you very much. To the members of the U.S. House Select Committee on Hunger, I want to thank you for giving us an opportunity to accompany you in looking at some of the homes in Leflore

County. Also, I want to take this opportunity to welcome you to the State of Mississippi on behalf of Governor Allain. We appreciate your presence here to examine the extent of hunger—a condition that taps the consciences of all caring men and women.

I think that the statement by James Baldwin, "Everything that is faced cannot be changed, but nothing is changed until it is faced" is very appropriate today as we view hunger and other conditions here. I have prepared a statement for this committee that gives an overview of the programs that we have in Mississippi and the benefit levels.

Some of you have raised some interesting questions about what we are doing in Mississippi. We are very much concerned about hunger, we know it exists. We realize that there are many gaps in services by the programs that are provided.

Mississippi is a State with a low tax base and our Governor has today called a special session to try to look at raising taxes to address the special needs of our State to get us through the remainder of this fiscal year. We have been a State that has been dependent upon Federal assistance and we have lost $1 billion in Federal assistance since 1981.

I think it is significant that the U.S. Congress has formed a committee to review hunger in this State 20 years after the beginning of the war on poverty. It is safe to say that we have made some progress, but the number of people joining the poverty rolls has increased over the years.

Mississippi is a rural State with 53.7 percent of its population living in rural areas. Twenty-four percent of all of our people live in poverty. This is the highest percentage of any State in the Nation. According to the 1980 census the number of Mississippians at or below the poverty line has increased. We have 24 percent of our people at the 100 percent poverty level. Mississippi has the lowest per capita income of $7,409 as compared to the U.S. average of $10,495.

The war on poverty programs did bring a lot of attention and programs to address hunger in the State and we have today staff who head various State agencies to expound more on these programs.

The State department of health operates the WIC Program which provides supplemental foods to some 87,000 women, infants, and children monthly. The fiscal year 1984 funding level is $31 million. The average food package cost was $23.26 per participant in fiscal year 1983, which is $2 less than the average cost of a food package cost in other southeastern regional States. Largely due to the WIC Program, our infant mortality rates are improving and we don't have to comment on the importance of adequate nutrition and protein intake for the pregnant mother.

The department of public welfare operates the Food Stamp Program and Aid to Families with Dependent Children. We expend some $260 million in this State. We serve probably about 164,000 households. That comes out to about $43 per month per person averaging about 47 cents per meal.

In view of the State's economy and income levels and high unemployment rates, it is easy to surmise that many elderly and disabled citizens living on a fixed income at the 130 percent poverty level are hungry because the necessities of life—medical expenses, high utilities and other services necessary to survive—require a great portion of their fixed income.

The AFDC Program provides assistance to needy families and annually the AFDC Program serves 633,690 families in the State and 1,337,993 children with recipients totaling 1,845,691 annually. The average AFDC payment is $43 per month per child serving about 111,824 children per month. This is according to the latest May printout from the department of public welfare.

The department of education operates the school programs, the Child Care Food Program, the Summer Food Services and Food Donation Program. The School Breakfast and Lunch Programs are made available to public and nonprivate schools, high schools and grade schools. As State officials, we will make an effort to encourage greater participation by our citizens in these programs. Good nutrition is very important to the development of children and a hungry child cannot learn at the same pace as the counterpart who is not hungry.

The average daily participants for the Breakfast Program is 118,541 participants and for the Lunch Program is 370,829. The number of schools on the Breakfast Program is 547 and the number on the lunch program is 940.

The Child Care Food Program is available for public and nonprofit private day care centers, recreation centers, family and group day care homes, Head Start centers, institutions providing day care for handicapped children. The program serves an average of 28,068 people daily. The Federal funding level is $10,429,516. You will hear more about these programs from the participants.

In view of time, let me now comment on the losses that our State has encountered since 1981. To the extent that we have made some progress, I think you have seen today with your visits that we have not been able to eliminate hunger and believe me, the Governor's office of Mississippi shares in that responsibility and wants to do our part in partnership with the Federal Government in bringing about the alleviation of hunger in this State. We take full responsibility and do not want to close our eyes to the existance of this.

Our State has lost a total of $1 billion in Federal aid since 1981, an amount equal to $397 per person in the State. It ranks first in the country in losses for child nutrition, second in losses in health services, third in lost funding for educationally deprived children and Appalachian Regional Programs, fifth in community services losses, eighth in social services and rehabilitation services losses, and ninth in lost funding in education.

The losses in payments to individuals totaled $315 million or $123 per person. Mississippi ranked second in per capita income losses in the food stamps and supplemental security income reductions.

I believe it is time that we redirect our social philosophy. It is time again to believe that the Federal Government should spend money to take care of its people. I believe that Federal funds should be used as a tool to guarantee and improve the general welfare of its people. More importantly, I think Government should be caring. Those of us in Government should be challenged by the information and statistics we will hear on hunger in this State. We must work to continue these programs. We must join in partnerships with businesses, private, nonprofit social and civic organizations and churches to create an awareness if that is needed, and to increase our efforts through these programs to ensure that not one child goes to bed hungry in our State.

It is the responsibility of government to care for its people and government can be an advocate of what is truly needed for the development of its people. As government officials on State and national levels, we should be catalysts, initiators, enablers, and facilitators for the needs of our State, our Nation, and our people.

The people have placed their trust in our leadership, to be responsive and responsible. Let's not close our eyes to what is real in fear that we may be blamed for its existence. Rather, let's face the situation and move to strengthen our programs, to address conditions such as hunger and look for innovative ways to form stronger partnerships in our community, our State, and our Nation.

We pledge the support of the Governor's office in doing what we can on a local level. We ask assistance of the Federal Government because the problem is too massive for our State, given the state of the economy, to address alone. We are making efforts to increase and improve our educational systems, to look at expanding and bringing industry to this State. But again, as Congressman Franklin has pointed out, Mississippi has got to do a lot to improve its public image within the State and abroad. We join in that partnership.

We also, out of the Governor's office, administer the Low Income Home Energy Assistance Program, Weatherization and Aging Program, and with me today is Michael Raff, director of the Governor's office of human development within the office of Federal-State programs, to discuss those programs with you.

Thank you for giving us this opportunity to be with you.

RESPONSES TO QUESTIONS FOR BEVERLY W. HOGAN

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. According to your State Department of Welfare, Office of Public Relations, the average Aid for Dependent Children, ADC, monthly benefit is the lowest in the Nation, and you have no income supplement program for children in two-parent families. How much does this determine the standard of living for participants?

Answer. No response received.

Question. How much money comes to this State from federally assisted rental housing?

Answer. No response received.

Follow-up: How much more would be needed to meet the need we have seen this morning?

Answer. No response received.

Question. We've heard stories of food stamp recipients selling their food stamps to pay utility bills, can you comment on this from your perspective as director of the Low Income Energy Assistance Program?

Answer. No response received.

Question. When cuts were made in Federal ADC funds how did that affect recipients in Mississippi?

Answer. No response received.

Question. From your experience with the administration of health, social and human services block grants in Mississippi, how would services be affected if Federal food assistance programs were block granted?

Answer. No response received.

QUESTIONS SUBMITTED BY HON. LEON PANETTA

Question. Doesn't the 6 percent sales tax on food hurt the ability of low-income persons to feed themselves? Why shouldn't Congress prohibit the collection of sales tax on food stamp purchases?

Answer. The enactment of a 6 percent sales tax does negatively impact the poor. The largest expenditure of the poor is for basic needs, specifically food. Consequently the application of a 6 percent sales tax on this commodity disproportionately impacts the poor and significantly reduces their ability to feed themselves. Congressional action is desirable in that this burden would be lifted nationwide.

Question. The maximum ADC benefit in Mississippi is $96 a month for a family of three and $120 a month for a family of four. Why are ADC benefits in Mississippi so low? How do people get by on this amount?

Answer. Mississippi has historically been a State lacking in economic and financial resources primarily resulting from a low tax base. This factor combined with a conservative legislative body had resulted in low ADC payments in Mississippi and other underfinanced social services. Frequently families exhaust their food stamp resources long before the end of the month. Hunger is the obvious consequence and is prevalent.

Question. H.R. 5151, the Hunger Relief Act of 1984, would make important benefit restorations in the Food Stamp Program. Under the bill, food stamp benefits would be based on 100 percent of the thrifty food plan in fiscal year 1985 and 101 percent in fiscal year 1986. Assets tests would be updated and the shelter and earned income deductions would be expanded. Do you support such changes? What others would you recommend?

Answer. The expansion of the food stamp benefits to 100 percent of the thrifty food plan and subsequently to 101 percent is a minimum step toward establishing an adequate benefit program. The assets tests and expanded deduction would also marginally expand the eligibility to include other poor in the program. A more realistic approach may be to increase the benefits to 110 percent of the USDA food plan.

QUESTIONS SUBMITTED BY HON. MARGE ROUKEMA

Question. What family planning problems are available statewide and in Leflore County?

Answer. A statewide family planning program operated by the Mississippi State Department of Health serves every county through 175 clinic sites. This program is serving more than 90,000 patients each year; a third of these clients are under age 21. The Department of Health Family Planning Program operates through the county public health departments. All health department family planning services are available on a sliding fee scale basis, with no payment required for patients at or below 150 percent of poverty level. All family planning services are free to teenagers. Additional family planning programs are operated by primary care centers around the State. There are 23 community health centers and rural health initiative programs in Mississippi, and each offers family planning services. In Leflore County, health department family planning services are available through the full time health department and one part-time satellite clinic. The target population for family planning services in Leflore County is 3,470. There were 2,033 users in calender 1983; 1,907 of these met the target population criteria—women over 20 at or below 150 percent poverty level plus all sexually active teens—for a rate of 55 percent served.

The health department has just implemented—July 1—a special title X project to reduce teenage pregnancy in Leflore and 12 other counties. This project features a case management approach with outreach services and intense followup activities to bring in more teens for family planning services and to be sure they remain on the program. In Leflore County, there are also two private OB/GYN's who accept medicaid patients and are considered emphathetic with the family planning target population.

Question. Specifically, what are the range of services available for all age groups?

Answer. The health department family planning programs provide comprehensive education, counseling, and medical services including contraceptive supplies. All users are scheduled for a complete medical exam annually by a physician. Revisits for resupply of contraceptive materials are individualized according to a patient's needs. The health department clinics offer several lab tests such as urinalysis that are not required by title X program. These are routinely done because of the high health risk of the patient population and the relatively low cost of the screening procedures. The services described above are the same for all age groups.

Question. How are potential participants made aware of these programs?

Answer. The best advertisement for family planning services has proved to be word of mouth. The health department does feature an extensive public relations campaign including school presentations, television talk shows, and newspaper articles aimed primarily at teenagers although age is not a barrier. Patients are also referred to family planning programs from other health department services and from other agencies such as the Department of Public Welfare. In Leflore County, the welfare department is next door to the health department and the referral patterns are good.

Question. Do you believe that an increase in family planning programs would be beneficial for Leflore County?

Answer. The Mississippi Delta has the highest teenage pregnancy rate in the Nation. The new project mentioned in the question above will be bringing more patients into the family planning clinics. The numbers may require more clinic staff or sites to fully serve all patients. More funding could definitely be utilized to ensure provision of services to those brought in by the increased outreach.

Question. In your statement, you state that one-third of the population of Mississippi is at 130 percent of the poverty level, but less than one-fifth participate in the Food Stamp Program. Is there any specific information available which would indicate why the level of participation seems as low as it does?

Answer. There is no specific information available which would document why the level of participation in the Food Stamp Program is as low as it is. However, from observation there are several factors which may prohibit the participation.

1. The lack of public and private transportation and the cost of that transportation in sparsely populated rural areas prohibits participation. Sometimes the cost of transportation is equal to or exceeds the food stamp value for participants.

2. Mail issuances are reduced because of losses. Some areas continue to experience a loss rate which exceeds the tolerance level. Therefore, in those areas, mail issuances have been discontinued. Hence, there is a decline in the number of food stamp recipients.

Question. You listed a number of spending categories in which Mississippi ranks high in low funding since 1981. How have you arrived at these figures? What specific categories constitute Federal aid? Does this mean there has been a drop in the actual dollar value of benefits received by an individual since 1981?

Answer. The Governor's Office of Federal-State Programs maintains an ongoing analysis of the levels of Federal funds coming into Mississippi. The categories studied include all the block grants and more than 40 other program areas ranging from education to food stamps to employment and training to housing and Federal aid programs to State and local government.

The losses calculated in the report reflect the real changes in program levels given changing economic circumstances.

The ranking of per capita cuts indicates the level of need of a particular State for a certain program, since Federal assistance is targeted on the basis of need. Thus, the greater the need for a program, the higher the per capita loss in that program.

Question. Is the Governor's Office making any specific efforts to encourage private involvement in food distribution programs?

Answer. In 1982, the Governor's Office of Federal-State Programs assumed the responsibility of administering the Emergency Food Distribution Program. During this period, efforts were made to identify private entities as food banks to participate in the program. At that time, the nearest food bank was located in the State of Alabama. There was no private entity which qualified for participation in the program.

Presently, the Emergency Food Distribution Program is administered by the State Department of Public Welfare and the Food Donation Program is administered by the State Department of Education. The Governor's Office, at the present time, is not directly involved with the Food Distribution Programs but offers technical assistance and support in getting private sector involvement to the State agencies that are involved.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. There are many Federal programs available for people in need here in Greenwood and across the United States. Can you tell us what special State program may be available. Have they, like the Federal programs, grown in the number of people served and money spent as the Federal programs? Please be specific. Any general relief, State emergency aid programs.

Answer. Mississippi provides matching funds for many of the Federal programs for the needy in the State. There are no programs funded exclusively by the State of Mississippi for people in need.

Question. Many Governors have set up hunger commissions to ensure that the needs of their citizens are evaluated and met through both Government programs and volunteer efforts. What has Mississippi done?

Answer. In Mississippi, a hunger commission has not been formed to ensure that the needs of its citizens are evaluated and met through both governmental programs and volunteer efforts; however, advocacy groups, such as the Southern Rural Women's Network and Mississippi Human Service Coalition have been taking an active role.

Question. Please explain the surplus commodity distribution programs in Mississippi. In 1983 almost $12 million worth of surplus commodities were made available to Mississippi. Can you describe your program and the eligibility criteria you set? I believe that the method chosen by States to distribute surplus commodities can determine how participants view this distribution program. A distribution system that is convenient and less demanding may have better results. Please comment.

Answer. The eligibility criteria for receiving commodities are basically the same ones used for other food assistance programs. Eligibility is determined by income, number in household, savings, utilities costs, ownership of car, and housing costs. Lists of those receiving food stamps are compiled by the computer by counties and distributed to the local welfare offices. If a person does not receive food stamps and meets the criteria mentioned above, he may go to the local welfare office and receive a voucher to be able to receive commodities. Public notices are given by the news media and word of mouth of the time and place for the distribution. Places of distribution varies from county to county. Such places as the National Guard armory buildings or the fairgrounds are used. Places must be large enough to accommodate large crowds and still have enough room for the commodities.

The commodities are given out quarterly; but in the near future, the food will be distributed six times a year. The primary products for distribution are cheese, butter, and honey. During the actual distribution, lines are long and recipients often have to stand in the heat or cold to receive commodities.

Question. One program you have is the Aid to Dependent Children (ADC) Program. What are the benefit levels and how are they determined? Has there been an increase in ADC benefits recently?

Answer. Mississippi is the only State with an Aid to Dependent Children Program. The maximum on the money payment to the recipient is: First child, $60 a month; second child, $36 a month and each additional child is $24. Therefore, the maximum for a family of three is $96 and for a family of four $120.

Need determination

1. Based solely on the number of children, provides no amount for needy parents or guardians.
2. Income and need standards.

The present payment has been in existence since July 1978. The payment was increased from $30 a month per child in 1969 to $60 a month per child in 1978.

Question. Are there any nutrition education programs in the public schools in Mississippi?

Answer. Since 1979, the State Department of Education, through its child nutrition programs, had provided nutrition education training (NET) for elementary, junior high, and high school teachers along with food services personnel and cafeteria managers. The training has been in the form of workshops which are held in various school districts. Generally, there are approximately 10 workshops held throughout the State, each focusing on two major objectives: To disseminate nutrition knowledge to a group of teachers and cafeteria personnel who have no special training in nutrition and to expose these persons to interdisciplinary nutrition education techniques and aids. From this training it is expected that the workshop participants would integrate nutrition education into their classroom teaching and cafeteria meal planning. Second, to foster communication and cooperation among teachers, administrators, and school food service personnel for the purpose of disclosing and solving existing nutrition education problems in the school. In fiscal year 1984, the State Department of Education, through contractual arrangements with the University of Mississippi School of Home Economics, conducted three workshops with an average of 25 persons in attendance at each. These workshops are made possible through a basic grant of approximately $50 thousand from the U.S. Department of Agriculture.

[The prepared statement of Ms. Hogan appears at the conclusion of the hearing, see p. 74.]

Mr. PANETTA. Mr. Raff.

Will that one reach? The microphone is too short.

This is Mr. Raff who is director of the Office of Human Development of the Office of the Governor.

STATEMENT OF MICHAEL RAFF, DIRECTOR, GOVERNOR'S OFFICE OF HUMAN DEVELOPMENT AND ACTING DIRECTOR, MISSISSIPPI COUNCIL ON AGING, STATE OF MISSISSIPPI

Mr. RAFF. I speak to you as director of the Governor's Office of Human Development and also as acting director of the Mississippi Council on Aging.

Before joining the Governor's staff last January, I——

Mr. PANETTA. Excuse me, Mr. Raff, would you get as close as you can to the mike so people can hear you. You may just want to take it off.

Mr. RAFF. Before joining the Governor's staff last January, I spent 14 years as the director of the Mississippi Council on Human Relations and then as director of the Mississippi Legal Services Coalition. It was the Council on Human Relations that brought those physicians to Mississippi back in 1967. In these capacities I have been working with communities in need and the programs that are designed to meet those needs.

I am familiar with the problems of the poor in this State with the highest poverty rate in the Nation, and have worked for the enactment and effective implementation of programs to alleviate these problems.

During these last 14 years I have seen significant gains in Mississippi in the fight against poverty and hunger because of a Federal commitment to programs that address the specific needs of the poverty population and I would like to stress that it is because of a Federal commitment to programs that address the special needs of the poverty population.

We have attacked hunger with food stamps and it notably reduced debilitating malnutrition among our people. Other nutrition programs supplemented this basic program and were targeted on particularly needy groups such as pregnant women and the elderly. Other poverty programs have helped families get their feet on the ground so that they could fight off economic deprivation. Civil rights compliance helped many black citizens gain an opportunity for education and economic opportunity.

Together this array of programs have reduced the amount of poverty in our State and set a base of decency for those unfortunate enough to remain below the poverty level. The recession and the failure of the Federal Government to adequately respond to the conditions produced by that recession have caused us to begin a backslide.

We need to once again take the road toward eliminating poverty and its devastating effects on our people. This will take a renewed commitment to programs targeted at the needs of the poor and their communities. As you heard, we have about one-fourth of our population mired in poverty—most of them struggling with part-time or off-and-on employment to pay their ever-increasing bills. The increase in utility costs and the inability to find stable work has drained the capacity of thousands of Mississippi families to meet their needs.

With the help of the Federal nutrition programs, people are able to eat most of the time, but not all the time. Food stamps run out before the end of the month and the households are called to make hard decisions. Essential needs, not frills or extras, frequently compete for food. Whether to heat their homes, to fill their drug prescriptions, to pay their rent or to eat are the choices they have to make.

Today you are in Leflore County which is in worse shape than the State as a whole. Thirty-four percent of the population live in poverty. Twenty-six percent live below 75 percent of that poverty level. The situation is particularly critical for children with 46 percent living below the poverty level and with elderly with 38 percent below the poverty level.

The Federal Elderly Nutrition Program has certainly assisted some elderly Mississippians. They serve over 12,800 meals a day. However, this represents only 3 percent of the older population of our State. And please remember, 188,560 or 31 percent of Mississippi's elderly live below the national poverty level. This percentage is by far the largest in the United States which has a national average of only 13 percent.

The federally funded Low Income Home Energy Assistance Program and the Weatherization Program have assisted some Mississippians through our freezing winters. But—however, here again most poor Mississippians went unassisted. According to the 1980 census, there are approximately 260,000 households that are eligible for assistance under these programs. Maximum utilization of the program funds resulted in less than 30 percent or 70,000 households being served last year.

This morning you went into the community and saw people facing these problems. I can assure you that Mississippi is filled with people who, through no fault of their own, are in financial straits—who suffer from hunger as a result of poverty.

We call upon you for assistance. You can increase the Food Stamp Program so that it more adequately meets the needs of the hungry. You can insure that successful programs like Head Start, WIC, Elderly Nutrition, Legal Services, and Community Action are kept strong so they can provide a resource for hungry people. You can give us programs that will enhance the opportunity of people to get jobs, adequate housing, health care, and food so our people can have pride.

Our people are a precious resource. If we have a commitment to human decency, if we have an understanding that our communities and our Nation cannot afford to push a significant segment of the population beyond the reach of essential services, then we are going to fight to provide these services that will enable all the—all to have the opportunity to live with decency and hope in their lives. We must be committed to this American ideal.

Thank you.

[The prepared statement of Mr. Raff appears at the conclusion of the hearing, see p. 76.]

Mr. Panetta. Thank you very much, Mr. Raff.

Mr. Fraiser.

STATEMENT OF JOHN A. FRAISER, DEPUTY COMMISSIONER, CLIENT/FIELD SERVICES, MISSISSIPPI DEPARTMENT OF PUBLIC WELFARE

Mr. **Fraiser**. Mr. Chairman, I have a written statement I would like to make a part of the record, please.

Mr. **Panetta**. You sure aren't going to be able to give that one.

Mr. **Fraiser**. I would like to make it part of the record.

Hunger is a real part of life for too many Mississippians.

Mr. **Panetta**. If you could get as close to that mike as you can, because the mikes aren't working, I would appreciate it.

Mr. **Fraiser**. Too many children still go to sleep hungry with the knowledge there will be no nourishment in the morning. Many elderly, who may not be eligible for any assistance, have to make basic decisions on whether to buy prescribed medicines or food.

The Food Stamp Program is the largest of the Federal food programs available to Mississippians and just since 1981 the needs have grown significantly.

The yearly allotment balance is up over 15 percent. The more I see of this program, the more I am struck by the changes in the program. Our first Food Stamp Manual was dated 1965. It contained 40 pages. Our 1983 manual, after the last revision, is 978 pages. What a change.

More now than ever legislative and regulatory mandates to reduce error rates, identify ineligibles and effect recoveries are with us and every year the Food Stamp Program has been the target of some change in law. The regulatory change has been even greater. In the past 30 months, there have been 90 significant changes; that is one every 10 days. The costs of these changes are great. These changes not only cost to effect that revision, but the error rate, by which we are judged, goes up every time there is a change.

What this program needs is stability. It must continue as a cornerstone of the food programs, but give time for the changes already made to show the effect. State administrators and county workers are just as competent and concerned with fraud, waste, and abuse as are Members of Congress and the USDA.

Many States believe strongly that sanctions are not needed to motivate them to reduce errors and detect fraud. The reduction and elimination of program abuse is a major concern of the States. Our error rate in Mississippi has dropped from 13.6 to 7.7 percent in the last several years. We held 611 food stamp fraud hearings in 1982 compared to a national average of 226. Fraud prosecutions totaled 365 in Mississippi compared to a 192 national average. Our administrative costs were $49.56 per case. This was the 48th lowest in the Nation.

I believe this demonstrates we feel a commitment to reducing errors and reducing frauds without sanctions.

Many other problem areas with this program, such as mail issuance tolerances, uniformity in eligibility determinations among programs involving household definitions, budgeting, resources and income determinations, monthly reporting and retrospective budgeting, uniformity of quality assurance regulations and policy with eligibility determination of caseworkers, and matching rates for systems development could have been and have been discussed by others. However, let me say that the foods program has made a significant contribution to not only the recipients in this case but to Mississippi's economy as well.

Now, let me address the Emergency Food Assistance Program, or, as we call it, the Food Distribution Program. This is a program that has provided an excellent supplement to the Food Stamp Program and one in which we are still seeing a rapid growth not only in Mississippi but in the Nation.

In July 1983, the Welfare Department took over this program from the Governor's Office of Federal-State programs. We agreed to take it on knowing that it was a big job and one that would likely increase in size, scope, and complexity. Our expectations have already been fulfilled and we think they are going to be exceeded.

Until now it was loosely run. By that I mean it was simple. They had few guidelines, little requirements for reporting, and less accountability requirements. However, since that time the regulations, requirements, accountability requirements, allocations, and the processes of certification and eligibility have multiplied, resulting in greatly increased administrative costs.

The myriad requirements, most of which we are told are due yesterday, can only lead to further increased costs. This program has not yet reached the level and complexity of the Food Assistance or Food Stamp Program and we will be able to handle it if we are not overburdened with Federal regulations.

The program must be kept as simple as possible while remaining accountable too.

We are committed to this program because we know it is greatly needed and is serving a terrific need, not only in Mississippi, but in the Nation.

One only has to go to a distribution site and see the thousands of people waiting in line for $20 or $30 worth of cheese, butter, rice, flour, or other products, to understand that this food is needed by the needy.

During our distributions, we distributed commodities to nearly 165,000 households each time. During the next year, at our present allocation levels, we will distribute over $17 million worth of food products.

And last, let me point out there will always be very significant costs associated with this program. We, as an agency, work hundreds of people during each distribution. We have not charged, nor do we expect we will be able to charge for our workers' time, but there will be costs for storage, trucking, security, equipment rentals, and many other areas. These are costs that we are now receiving 100 percent Federal reimbursement for and for which that level must be continued.

Our counties and our State cannot afford to take on any increased cost of new programs. This is a national program like the Food Stamp Program that must continue to be funded at the 100 percent level and at levels which will insure that the States can buy the help needed to distribute the food.

Thank you.

Mr. PANETTA. Thank you very much, Mr. Fraiser.

RESPONSES TO QUESTIONS FOR JOHN A. FRAISER

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Dr. Donald Roark, Commissioner of the Department of Public Welfare, testified before the President's Task Force on Food Assistance that 32.9 percent of Mississippi's population is income eligible to receive food stamps. Yet only 19.11 percent of those eligible participate in the Food Stamp Program. What do you account as reasons for this discrepancy?

Answer. I believe I addressed this question in the question and answer session following my address, and some of the reasons may be found on page 2 of my comments. I have enclosed a copy of Dr. Roark's testimony to Senator Helm's committee which you might find informative. He does address this question in it.

Question. What type of public information is provided to inform people of Food Stamp Program eligibility standards?

Answer. A few years back States were required to have active outreach programs, but no present requirements exist. Our efforts consist mainly of information being provided through county offices to the public.

Question. Mississippi began mail issuance of food stamps in 1979. Can you tell us how successful this service has been in getting benefits to the elderly, the disabled, and rural residents without access to transportation?

Answer. The mail issuance of food coupons has been one of the best things to happen to our Food Stamp Program in Mississippi. Certainly, thousands of elderly and disabled recipients are helped through this process. We have a very limited public transportation network in the State and many recipients had to pay $10 to $15 to get a ride to pick up their stamps.

Question. What do you find to be the advantages and the disadvantages of the mail issuance program?

Answer. The mail issuance of food stamps not only aids and is really more than a convenience for recipients who are elderly and disabled, but it helps our county staffs arrange a more orderly work flow. It reduces long lines for those who continue over the counter food stamp issuance.

Question. Can you detail for us changes you would suggest to make the food stamp operations more effective in the State of Mississippi?

Answer. I addressed several issues and recommended changes, if any are to be made, and I know some will and should be made.

a. First, please realize how seriously I mean that stability in the program is so important at this time. Few legislative changes, and even less regulatory changes would be a big help.

b. Seek uniformity between FNS and HHS Programs. Common eligibility requirements pertaining to household definition, income (net or gross), resources and budgeting would be a terrific help. Other Federal programs (SSI for example) use gross income, maybe this should be considered for the Food Stamp Program.

c. Mail issuance tolerances should be reconsidered, not only the 0.05 percent level, but the project area definition. Statewide we meet the 0.5 percent level, but some selected counties, which are our project areas in Mississippi, exceed that level. Putting a low tolerance level on States when they do not have full control of stamps issued through the mail system, but do have full financial responsibility needs to be addressed.

d. Seek uniformity of quality assurance regulations with eligibility determination regulations. Presently, quality assurance workers can make unannounced home visits and collateral contacts without prior approval, but eligibility workers on the front end can't do these things. This is an inequity that needs attention.

Question. Your department also has authority for operating the U.S. Department of Agriculture Surplus Commodity Distribution Program. In March, Mississippi was allocated 14 carloads of processed cheese—only 7 carloads were accepted. The allocation for butter was 6 carloads, and the State accepted none. In April, the State allocation for processed cheese was 15 carloads, yet only 7 carloads were accepted. The allocation for butter was 6 carloads, and only 3 were accepted. Can you explain to us why these commodities were refused?

Answer. When we took over this program, from another agency, there was only one USDA approved warehouse in the State, and it was being used not only by us, but also Commodities Credit Corporation was storing products there. That warehouse reached its capacity and could not handle any more loads. On an emergency basis, we put some products in a warehouse in Alabama. Now we have arranged for additional space in Memphis, TN, and also additional trucking firms. We are going from quarterly distribution to bi-monthly distribution and are taking 22 carloads of cheese a month now and increased allocations in other products.

QUESTION SUBMITTED BY HON. WEBB FRANKLIN

Question. In your testimony, you state that the Food Stamp Program needs stability with fewer regulatory changes. Are there specific program requirements currently in place which you feel can be eliminated to make the program run more smoothly without increasing error rates or decreasing benefits to particpants? Are there specific changes which you feel need to be put in place?

Answer. I hope that I have sufficiently addressed Mr. Franklin's question in answering Mr. Leland's fourth question. Again, I have enclosed a copy of Dr. Roark's testimony which addresses some issues needing attention.

QUESTIONS SUBMITTED BY HON. LEON PANETTA

Question. Are food stamp benefits adequate to feed needy persons in the State?

Answer. The Food Stamp Program and the benefits provided through it have certainly helped needy people, not only here but elsewhere. For those people at or near the 130 percent poverty level and for those who are near poor and don't qualify for assistance, in particular, they have a real plight in their lives though. They must make very difficult, daily decisions whether to buy food or seek medical help, to buy prescription medicines or pay a gas bill or to buy formula for their children or pay the rent. These people need more help.

Question. Doesn't the 6 percent sales tax on food hurt the ability of low-income persons to feed themselves? Why shouldn't Congress prohibit the collection of sales tax on food stamp purchases?

Answer. Certainly, the 6 percent sales tax on food reduces the amount of food a family can buy with its monthly allotment. I do not believe anyone relishes the thought of taxing basic necessities, but this is a poor State which has not had a wide base to raise revenues to carry on the functions of State government. More than one-half of our revenues come from the sales tax. Our other big source is the income tax revenue. This, thus becomes a question of legislative priorities of where and whom to tax. The revenues lost to the State by prohibiting the collection of sales tax would have to be made up elsewhere if the same level of revenues are needed, and I believe they are.

Question. Do some low-income persons have difficulty arranging transportation to get food stamps? Can mail issuance be utilized for all appropriate food stamp participants? If not, why not?

Answer. In Mississippi, we do not have a public transportation network in all areas of the State. We, in fact, have a very limited public transportation system. Many recipients still have to buy rides at $10 to $15 a time to get to the food stamp issuance sites. In spite of our best efforts, to control mail issuance losses, some areas continue to experience a loss rate that exceeds the tolerance level. In those areas we have had to discontinue mail issuance. We don't like this, but it's something we had to do to meet the tolerance levels that exist. Additionally, some food stamp participants want over the counter issuance only, even though we have informed them and encouraged them to participate in mail issuance.

Question. What is your view of monthly reporting and retrospective budgeting? Does it have an adverse effect on clients? Does it save any money?

Answer. I believe monthly reporting and retrospective budgeting should be made a State option. The results of studies made on this subject to date indicate that monthly reporting and retrospective budgeting raises administrative costs and benefit levels. I cannot see any money savings at this time. I gather from our counties that it increases the workload on our already overburdened staff.

Question. The maximum ADC benefit in Mississippi is $96 a month for a family of three and $120 a month for a family of four. Why are ADC benefits in Mississippi so low? How do people get by on this amount?

Answer. I do not believe a family can get by on that level. Our ADC payment level is so low that over 90 percent of our recipients receive the maximum grants. Raising three children on $60, $36, and $24 is more than a problem, it's next to impossible.

For several years, we at Mississippi Department of Public Welfare have requested an increase in ADC payments. We have approached it from several different avenues; taking the State maximum off, changing the rateable, including the adult in the payment, and raising the payments. This is also a question of legislative priorities. We, like a lot of States, and more so that most other States, have experienced very tight fiscal times and will continue to experience periods of budgetary restraints and fiscal cut-backs. Our State welfare board and our State Advisory Council have supported requests to raise ADC payments in the past and are again considering this issue now. Our role is to provide input to the legislature which we have done and will continue to do.

Question. H.R. 5151, the Hunger Relief Act of 1984, would make important benefit restorations in the Food Stamp Program. Under the bill, food stamp benefits would be based on 100 percent of the thrifty food plan in fiscal year 1986. Assets tests would be updated and the shelter and earned income deductions would be expanded. Do you support such changes? What others would you recommend?

Answer. If changes are to be made, then the ones you mention here are worthy of consideration. Raising the benefits to 100 and 101 percent of the thrifty food plan is a positive move. Generally speaking, changing the asset tests and shelter and earned income deductions should result in restoring benefits, and are favorably viewed. Other changes that I have addressed in response to questions by Mr. Leland and Mr. Franklin are highly recommended as areas needing attention and change.

[The prepared statement of Mr. Frasier appears at the conclusion of the hearing, see p. 78.]

Mr. PANETTA. Mr. Barr, who is director of the Mississippi WIC Program.

STATEMENT OF JOHN R. BARR, DIRECTOR, MISSISSIPPI WIC PROGRAM, MISSISSIPPI STATE DEPARTMENT OF HEALTH

Mr. BARR. Mr. Chairman and lady and gentlemen, I appreciate the opportunity to speak to you today in behalf of the over 153,000 potentially eligible WIC participants in Mississippi and also my colleagues who administer WIC Programs throughout the United States.

As you know, the Special Supplemental Food Program for Women, Infants and Children, commonly known as WIC, is a totally federally funded program administered by the U.S. Department of Agriculture through the Departments of Health in each State.

In addition, the program is offered in Puerto Rico, the Virgin Islands, Guam, the District of Columbia, and through 31 Indian tribal organizations.

In Mississippi we are able to serve more people with the funds we receive because of our unique system of providing a food package directly to our clients. Through a network of 88 distribution centers throughout the State, participants pick up a food package monthly from a local distribution center in their county of residence.

By letting bids for food products each quarter, we are able to purchase our food at much less than the retail price, or about $9 less per food package than other States.

Therefore, for every three persons enrolled, one additional person can be served with the savings realized. We now serve over 87,000 persons each month, or 57 percent of the potentially eligible women, infants and children in the State.

Because our 1984 grant will not sustain this number of persons, we are now taking steps to reduce our caseload by lowering the income guidelines to 133 percent of poverty from 185 percent.

This action is expected to reduce our caseload to about 84,000 persons per month by September 1984. Future reductions or increases will depend on the appropriation we receive for fiscal year 1985.

In the materials I furnished the committee prior to this hearing, a position paper developed by the National Association of WIC Directors at our February 1984 meeting was presented. While we believe all the issues addressed to be important, in the interest of time I will only discuss several of the most pressing ones.

The first and most pressing is since WIC was provided partial year funding of $1,060 million under the continuing resolution, the $300 million supplemental funding for July 10, 1984, to September 30, 1984, must be appropriated very soon to avoid major program disruptions.

This action, as far as I am concerned, has not taken place at this time and I understand there is a June 29 recess coming up, so I would ask your assistance when you go back.

State WIC Programs should be authorized end of year funding flexibility not to exceed 3 percent, to permit the most effective management and utilization of total funding. There are many uncontrollable variables which enter into the management of the program which make it difficult to utilize 100 percent of funding without the risk of overspending and that is what is happening to me right now.

At this time the only alternative for program managers is to cut caseload toward the end of a fiscal year when there is a possibility of overspending.

With authority to exceed the grant from 1 to 3 percent with a corresponding reduction in the following year's grant, States would have management flexibility which will allow for program stability.

I urge your support of this authority.

We recommend expanding the annual program authorization level by an amount equal to the determined inflationary increase plus 10 to 15 percent real growth in 1985. While this might seem excessive in light of the current budget deficits, we believe the program to be cost effective and by meeting this need may contribute to significant savings in future medical costs.

While no major studies have been completed on the effects of the WIC Program in Mississippi, one of the major goals of the program, to improve the health and nutritional status of infants and children, is certainly being met.

In 1975, 1 year after WIC came to Mississippi, the infant mortality rate for the State was 22.5 deaths per 1,000 births.

In 1982, 7 years later, that rate had been reduced to 15.4 deaths per 1,000 births, and Mississippi no longer led the Nation in infant deaths. Other statistics, such as low birth weights and low gestational age infants, have likewise been reduced.

While the WIC Program does not claim full credit for these improvements, the impact of the program is evident. Of the almost 46,000 live births in Mississippi in 1982, the program provided service to over 40 percent of those mothers.

Nonfood program costs should be defined as direct services and operational costs which includes nutrition-health assessments and nutrition education, plus local and State administration.

Presently, the annual grant is divided into two categories—food and administration. Recent proposals to cut costs by reducing the percent of the administrative grant from 20 percent could be devastating to the program.

We believe the term administrative costs to be a misnomer since these also include payments for many client services such as nutrition and health assessments and nutrition education, plus local and State administration.

In Mississippi our administrative costs also include the rent and utilities for the warehouse space which is included in the cost of food in other States.

Therefore, we respectfully request the definition of administrative costs be expanded to identify the other services provided with the moneys and that the minimum funding for direct services and operational costs should be 20 percent of the total grant.

Finally, I would like to thank Congress for the past support provided the WIC Program and assure you of my commitment to responsibly manage the program to the benefit of those women, infants and children in Mississippi who need our service.

I thank you.

Mr. PANETTA. Thank you very much, Mr. Barr.

RESPONSES TO QUESTIONS FOR JOHN R. BARR

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. I am aware that your system of food distribution for WIC is the only statewide program providing food from local warehouses, as opposed to the voucher, or a combined system. What are the advantages and disadvantages of using such a system in your State?

Answer. The direct distribution system—warehouse—of food delivery is ideal for Mississippi because we are a rural State. The county seat is the center of activity for most of our residents. Therefore, with distribution centers located in every county seat, clients have a better opportunity to pick-up their food packages monthly. Our monthly participation to enrollment rate is 95 percent, which is better than most other States in the region.

We piloted voucher programs in 3 counties for 18 months in 1980 and 1981. Besides the costs being much greater, in one county it was difficult to locate enough grocery stores that were willing to stock some of the special products we provide—cereal—or had the space to store the quantities that would be required. By giving the food package directly to the participant, we know that each person receives exactly the type and quantity of food prescribed by the health professional.

Transportation is certainly a major problem for many of our clients. In one area, arrangements were made with a community action agency to provide transportation when requested by participants. We also encourage clients to car pool whenever possible.

The major disadvantage to the direct distribution system is that we are unable to provide fresh milk and eggs to all of our clients. Only 11 distribution centers issue fresh milk and eggs. Lack of refrigeration, and the inability to locate vendors willing to provide the products in some of our remote counties are the main obstacles. We, therefore, give most of our clients non-fat dry milk, evaporated milk, cheese, and dry egg mix.

In summary, the direct distribution system is, by far, the most cost effective. It is ideal for a rural State like Mississippi, but would probably not be as well accepted in most other States. The absence of fresh milk and eggs and the transportation problem are the two greatest disadvantages to this system; but due to the economy of the State, eligible persons take advantage of any opportunity to help feed themselves and their children.

Question. Please explain why you have chosen to lower the Mississippi WIC income eligibility level rather than focusing on those clients at highest nutritional and health risk?

Follow-up: How will you track the number of high-risk women and infants dropped off to assure they receive services again if funding becomes available?

Answer. Income eligibility was used as the vehicle to reduce caseload primarily because of the way the priority system is presently structured in the regulations. As you were told in Greenwood, Mississippi has the highest teenage pregnancy rate in the Nation. We believe this group to be one of the highest risk categories of participants both prenatal and postpartum. However, the postpartum woman is a priority VI or in the lowest priority group. Therefore, to use health risk as the method to reduce caseload would require that we deny service to our teenage mothers before we could restrict benefits to children with only a poor dietary pattern—priority V—as a health risk factor. The statement of concerns of the National Association of WIC Directors (NAWD), addresses this problem and is included in the record. We hope to get relief in this area when new regulations are published.

It should also be noted that, when using 185 percent of poverty as the guideline, a family of 4 could earn $18,870 per year. Under the 133 percent of poverty guideline, that same family can only earn $13,565 per year; which still allows us to serve the most needy in our State.

Former WIC clients who are patients of the county health departments and independent health agencies will automatically be offered WIC Program services should funding allow caseload expansion. Also, through our computer program, we are able to identify high risk patients by name, address, and phone number. In the meantime, those who do not qualify for a supplemental food package may continue to receive free or reduced cost medical service through other MCH Programs. To further insure the latest information affecting caseload is disseminated, we would also send news releases to the media in all counties.

Question. What are problems specific to rural areas in meeting the needs of potentially WIC eligible residents?

Answer. As previously stated, transportation is one of the major problems associated with serving clients in rural areas. Since there is no public transportation, participants must rely on their own source, that of a neighbor, or friend or, in some cases, a church or civic group will provide transportation.

Getting out the word on the availability of program service is also difficult in rural areas. To help with this, we ask our local level people to advertise our service in the local newspapers and on radio and TV at least quarterly.

At the State level, we issue at least one major news release statewide, to all media, annually, announcing the service we offer. We also use the bulletin boards in churches, shopping centers, etc. to display our posters.

Question. Could you please expand on the comments in your testimony as to how WIC's current funding levels affect your State's ability to maintain and expand its caseload and to reach those pregnant women and infants at highest risk of low birth weight and infant mortality?

Answer. Because of the $2.2 million Jobs bill money the Mississippi WIC Program received in fiscal year 1983, we were able to expand our caseload from April 1983 to September 1983 by 17 percent to 81,807 participants. Funding for fiscal year 1984 was based on September 1983 participation times the average food package and administrative cost per participant times 4 percent for inflation.

We made no attempt to restrict enrollment of WIC clients in an effort to determine just how many of the potentially eligible persons might request service. As you were told in Greenwood, we served over 87,000 persons in May 1984, an increase of 6,000 over September. In order to accommodate this number of people, we tailored the food package in January 1984. As an example, we discontinued peanut butter and substituted the alternative; dry peas or beans, at a savings of 70 cents per woman and child participant per month. Today, our total monthly cost per participant has only increased 17 cents over fiscal year 1983. Granted, we are not providing the maximum allowable quantities of all items nor the most popular product, peanut butter; however, we are serving more people than our funding would have allowed otherwise.

Not withstanding these efforts to cut costs, our fiscal year 1984 funding is insufficient to continue service to this number of people through September without exceeding our grant. Consequently the decision was made to lower the income guideline to 133 percent of poverty. While we have no idea to what extent this will effect caseload; we will analyze the results monthly and make adjustments in the poverty guideline accordingly.

If States were given the authority to overspend the grant amount by from 1 to 3 percent, more effective management and stability of the programs would result.

In our case, we could continue to serve our present caseload and, after the fiscal year 1985 appropriation was announced, make any necessary adjustments over a 12-month period instead of 3 months.

I have enclosed a letter from the NAWD to Senator Jesse Helms (attachment 2) who recently proposed legislation which would radically alter the ability of the WIC Program to function as it was originally intended. I include this so that should this type of legislation ever reach a joint committee hearing, you would be able to advise your collegues in the House of the adverse consequences of such action.

QUESTION SUBMITTED BY HON. WEBB FRANKLIN

Question. Mississippi has received national attention for the efficiency of its WIC distribution system. Are there any administrative measures or features of that system which, from your observations, could be applied to other food distribution programs?

Answer. Unfortunately, I am not as familiar with other food distribution programs as I am with the WIC Program. However, as I pointed out in my first letter to the committee, I cannot advocate our distribution system for other State WIC Programs. First, most States have been operating a retail delivery—voucher—system for 10 years and have invested many thousands of dollars in sophisticated data processing programs to account for the funds expended through that system. To convert to our system would be very expensive and not cost effective. Second, I do not believe a direct distribution—warehouse—system would be widely accepted by WIC clients in most nonrural States. Centers of population are more disbursed which would not lend itself to centralized distribution centers.

I do understand the Mississippi School Lunch Program now uses a modified bid system to procure food products not provided by USDA. This has proven to be cost effective, according to Mr. John Walker, and would most probably have application in States which presently allow their school districts to individually purchase food items.

Finally, I believe that one of the most positive aspects of the WIC Program, aside from nutrition education, is the fact that we specify the type and quantity of food products our clients may receive. If the Food Stamp Program could, in some way, limit the amount of junk food and specify the type of nutritious foods that could be purchased; the nutritional status of those clients would certainly be improved.

[The prepared statement of Mr. Barr appears at the conclusion of the hearing, see p. 84.]

Mr. PANETTA. Ms. Murphree, Chris Murphree, who is the food assistance supervisor, Leflore County Welfare Department.

STATEMENT OF CHRIS MURPHREE, FOOD ASSISTANCE SUPERVISOR II, LEFLORE COUNTY FOOD STAMP OFFICE

Ms. MURPHREE. Thank you.

According to the 1980 census, Leflore County has a population of 41,550. Of this number, an average of 11,281 people have received food stamps each month in the past year. This is 27.15 percent of the population of the county. Food stamps are available to everyone who meets the criteria as outlined by Congress. This includes meeting income and resource guidelines plus other guidelines such as residency and work registration job search.

Food stamp applications are lengthy and ask indepth questions but this is necessary in order to correctly certify a household for food stamps. In fact, 30 pages is a minimum for an application, this right here [indicating].

The Food Stamp Program is a supplementary program. It is not designed to be the full monthly food allowance. Along with other programs, it is designed to supplement a household's income.

Other programs available are Aid to Dependent Children, which is a monetary payment which includes medicaid coverage, the WIC Program, which issues commodities to pregnant women, nursing women, and children through the age of 6 on a monthly basis, breakfast and lunch programs are available in the school systems and the Head Start Programs.

Commodities including cheese, butter, honey, dried milk, and flour have been issued on a quarterly basis in Leflore County in the past. They will be issued every other month in the future. This program is available to more people because the resource guideline is not a requirement. Leflore County has issued to approximately 12,000 people at each distribution.

Two ways that the Federal Government can make the program more effective are: One, stabilize the program; example: All changes during a year should be made at one time once a year or once every 18 months, not two or three changes each month.

Two, States should be required to have a certain number of workers per case count. This would involve putting more Federal money into the State to supplement the budget since Mississippi has less tax money available due to our low income. This would enable us to give quicker and more accurate service to the public.

Mr. PANETTA. Thank you very much, Ms. Murphree.

RESPONSES TO QUESTIONS FOR CHRIS MURPHREE

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. It is my understanding that food stamp applications must be ruled on within 30 days. I have a two-part question. How long does it take for an applicant coming to your office to be certified, and how long does it take after certification for that person to begin receiving food stamps?

Answer. Applications are handled on an as received basis. If all information is received an application is to be completed within 30 days, if the client does not send in all information in the first 30 days a notice is sent to him detailing what he must return to us to complete the application, then we have an additional 30 days to complete the application for a total of 60 days. Stamps are mailed or can be picked up as soon as the supervisors review the cases.

Question. In Leflore County, what criteria must an applicant meet to qualify for expedited service and how long does it take before a qualifying individual actually begins to receive food stamps?

Answer. Expedited services in Leflore County are available to anyone meeting the criteria as outlined by the Federal regulations. That is the households liquid resources must be less that $100 and the household's gross monthly income must be less than $150 or the household must consist of migrant or seasonal farmworkers defined as destitute. The timeframe for processing is 5 calendar days. Stamps are available to be mailed or picked up no later than the close of business on the 5th calendar day following the day the application was filled.

Question. You stated that an average of 11,281 people in Leflore County received food stamps during the past year. Can you give us some insight into how many people at the present time are potentially eligible for food stamp benefits and are not receiving them?

Answer. Information not available.

Question. If there is a seasonal increase in the number of people making application for food stamps, can you detail how your caseload might fluctuate and to what factors you attribute the increase in applications?

Answer. Applications increase in the timeframe of December through March each year when farmworkers are out of work.

Question. How many people in Leflore County now receive food stamps by mail? Follow up question: What criteria do you use for determining who is eligible for food stamps by mail?

Answer. Approximately 1,000 households.

Food stamps are mailed to households who desire mail issuance who receive $100 or less in coupons each month.

Question. How does an applicant qualify for telephone certification?

Follow-up question: Are the elderly, disabled, and persons living in rural areas of the county without access to transportation generally approved for telephone certification?

Answer. A telephone interview can be used every other certification if due to age, mental or physical handicap or certain hardship conditions a household cannot come in for a face to face interview or cannot authorize a representative to come in for him. A face to face interview must be held every other certification.

Question. What changes would you suggest in certification regulations to allow a food stamp caseworker to serve more clients?

Answer. Paper work is tremendous, additional funds to hire additional caseworkers and case aides would help caseworker to serve more clients.

Question. You also work directly with the local distribution of U.S. Department of Agriculture surplus commodities. How and where are the commodities distributed; i.e., must people come to the Welfare Department to pick up commodities, are there satellite distribution sites for persons living in rural areas?

Answer. Commodities are distributed only in Greenwood. They are issued to all food stamps recipients and other households who make applications.

Question. Do you have services for getting commodities to the homebound elderly and disabled?

Answer. Central Mississippi Inc. and the homemarket service at the welfare department distribute commodities to the homebound elderly and disabled. Also anyone who cannot come can send a representative.

Question. You stated that you are able to serve more people because the resource guideline is not a requirement. How do you determine who is eligible to receive surplus commodities?

Answer. All food stamp recipients are automatically eligible to receive commodities. Anyone else may apply who meets the food stamp income guidelines. We have not been asked to verify resources on these self-declared households.

Question. How do you make the public aware of scheduled commodity distribution dates?

Answer. Public announcements on radio, TV, and in the newspaper make the public aware of scheduled commodity distribution. Also it is announced to food stamp recipients at the food stamp office.

QUESTIONS SUBMITTED BY HON. LEON PANETTA

Question. Do some low-income persons have difficulty arranging transportation to get food stamps? Can mail issuance be utilized for all appropriate food stamp recipients? If not, Why Not?

Answer. Mail issuance is offered to all households who receive less than $100 in food coupons. Due to the great mail loss we have to limit the value of the coupons we mail. Public transportation is available from outlying areas to the food stamp office for minimal fee.

Question. To what extent do food stamp participants find it necessary to sell some of their food stamps in order to meet other pressing needs?

Answer. Selling food stamps is against regulations. All recipients must sign an application form stating they understand that it is illegal to sell their food stamps.

Question. To what extent must local food stamp participants rely upon small, local stores because these stores grant credit to customers who are out of money? Does this situation result in food stamp participants paying higher food prices?

Answer. I do not know to what extent clients use the small, local stores who grant them credit but I do know the smaller stores have much higher prices.

Question. What is your view of monthly reporting and retrospective budgeting? Does it have an adverse effect on clients? Does it save any money?

Answer. I like the way income is counted for monthly reporting—prospective and retrospective budgeting because it is a fair way to count the money as earned by a household but it is very time consuming and a number of employers do not like to fill out the forms each month. I cannot tell yet if it is saving any money.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. How many people receive food stamps in Leflore County?

Answer. 3,200 households or 11,281 people. All food stamp recipient household members are eligible for feeding programs.

Question. Do you take different applications and apply different rules for the same family for different types of assistance—such as food stamps, ADC, child care, or title XX benefits? What can be done about this?

Answer. Yes, different rules apply to each program. Uniform guidelines for all programs—same income, resource, verification guidelines—would make applying for benefits easier.

Question. Is your office involved in the Surplus Commodity Distribution Program? Please describe it.

Answer. The Surplus Commodity Distribution Program is available to all food stamp recipients every other month. Other families who do not receive food stamps may apply and be determined eligible according to food stamps income guidelines. Items distributed are cheese, butter, honey, flour, and dried milk.

Mr. **Panetta**. I am going to ask the members if they could keep their questions as few as possible because we are running on a tight time schedule.

Mr. **Franklin**. Mr. Chairman, could I be recognized just one moment on a matter concerning a request from another witness who was not allowed to testify but has submitted that testimony to me in writing and ask that I have it included in this record?

Mr. **Panetta**. Sure.

Mr. **Franklin**. This is the testimony from Mr. J.H. Walker who is assistant director of administration and finance of the State department of education. Mr. Walker is responsible for all of the special nutrition programs which includes the school lunch, school breakfast, food distribution, nutrition education and training, child care food program, summer food service, and the special milk program.

He had mentioned some $80 million in funding and I would like at this time, Mr. Chairman, to have his statement included at this point in the record.

Mr. **Panetta**. Without objection, and I might say that others who want to submit a written statement for the record will be permitted to do so.

[The prepared statement of Mr. Walker appears at the conclusion of the hearing, see p. 94.]

Mr. **Panetta**. Mr. Leland.

The **Chairman**. Thank you, Mr. Chairman. I have numerous questions, Mr. Chairman, but I am going to ask only one and it is going to be of Beverly Hogan whom we heard from earlier.

Ms. Hogan, according to your statement the average aid for dependent children, the monthly benefit from the welfare office, is the lowest in the Nation.

You have no income supplement program for children in two parent families. How much does this determine the standard of living for participants?

Ms. **Hogan**. I am going to refer that to Mr. Fraiser who works directly with that program.

Mr. **Fraiser**. We are not very well pleased in Mississippi and for a number of years the welfare department has asked our legislature for increases.

Right now in Mississippi we have a child maximum on the ADC law that allows to $60 for the first child, to $36 for the second child, and $24 for each additional child after that.

Our State has been really in a bind just like a number of other States. We have not been able to increase it. Certainly when you go through the determination process right now you look at our caseload and most of them, in excess of 90 percent, are drawing the maximum amount, which leaves that family in bad shape. It is hard to raise a child on $60, $36, $24, and so forth. We recognize the need and asked for it, but our State has not been able to do anything about it, nor do we have a public assistance program.

The **Chairman**. Doctor——

Mr. **Fraiser**. John Fraiser.

The **Chairman**. Mr. Fraiser, Dr. Roark, commissioner of the department of public welfare, testified before the President's Task Force on Food Assistance that 32.9 percent of Mississippi's population is income eligible to receive food stamps, yet only 19.11 percent of those eligible participate in the Food Stamp Program.

What do you ascribe as reasons for this discrepancy?

Mr. **Fraiser**. There are several reasons I can think of offhand. I think many considered the complicated eligible determination process just too difficult to get involved in. Many are physically unable to wait in long lines to receive food stamps in those areas where we have had to discontinue mail issuance.

Many do not have the transportation. Public transportation in Mississippi is very limited. In fact, it is nonexistent in parts of Mississippi.

Many feel the loss of pride and dignity to go participate in the Food Stamp Program. I think many who might be eligible do not participate because of perceived threats that they have of fraud and prosecution of abusing the system and that has a real strong effort for us lately.

Whether or not that's real, I think that perception might be there and I think some do not really participate because once they go there and they find out what the small amount of stamps they will receive—when you are looking at 130 percent of the poverty level; I think that amount that they receive discourages some.

I think there are several things that could be done that we could look at and I will mention them just briefly in passing. I think maybe look at the mail issuance program again and if we can, in Mississippi, being a rural State, I think that is a bar to us and we are, even though as a State we are under mail issuance laws, I think that as a whole we have had to discontinue mail issuance, which certainly has affected clients and one that we are not real pleased with.

I think if you look at uniformity in the determination process among AFDC and food stamps in particular, which I understand there is a Federal task force now, just looking at that, I think that certainly has the potential of making the programs uniform and simpler to operate. If it is simpler to operate for us as administrators, it is going to lend confidence to the public as well.

I think that we need, of course, to look at the monthly reporting in retrospect to budgeting. That is a big issue right now and I think Dr. York has addressed that in the past.

I think that some of the things that really make it difficult for us as administrators that might be dealt with is the uniformity of regulations between what happens after the fact of quality control and what happens at the front end.

Our caseworkers are not allowed to do certain things that a QC worker coming afterward can do which makes it much more difficult for us as administrators.

So I think those things are barriers to the program that we can look at, things that can make it easier and give a lot better confidence to the public, not only the people who receive it, but the taxpayers as well.

The **Chairman**. Mr. Chairman, I have several other questions that I would like to submit in writing to the respective panelists.

I would ask consent that those questions and the responses be submitted for the record of this hearing.

Mr. PANETTA. Without objection, members who wish to submit questions for the panel will be able to do so and, incidentally, that is 2 weeks for purposes of a written statement to be included in the record.

Mrs. Roukema.

Mrs. ROUKEMA. Thank you, Mr. Chairman.

Mr. Barr, I would like to have available here for you a recent bill that has been passed by the House, H.R. 7, that answers some of your very well stated concerns about the WIC Program.

Included in this new legislation will be at least two corrective measures that you correctly identified; one, the administrative questions and, two, the program insofar as the funding—the overlapping funding from year to year. I would like you to have this report. We will make sure that the staff gives it to you. It will not solve all your concerns, but I think you will be pleased with what you see there.

You will also note that the bill, as it was reported out of the Education and Labor Committee, recommended WIC as an entitlement program because, as you correctly observed, not all people eligible are being served under the funding restraints. But on the floor of the House before the bill was acted upon we had to delete the entitlement aspect of it for reasons that are quite obvious, the cost factors. But WIC is certainly recognized by Congress as one of the most cost-effective and valuable contributions we can make to good nourishment and healthy young bodies and minds, and I want to commend you for the work that you are doing.

Mississippi is noted for its WIC Program.

My question is a general one and it may be that only Ms. Hogan would like to comment about it and perhaps it is beyond your level of responsibility. Earlier today, as you and I were discussing what we were seeing there, we knew that poverty was continuing although we had gone a long way in conquering hunger. And we discussed why is Mississippi being passed by at least up until now in the revival of the Sun Belt in terms of economic revival, because what our people in Mississippi need are education and job training. But you told me that the job training, the education and job training and the jobs are lacking.

Would you like to comment on that?

Ms. HOGAN. Again, I would like to reiterate my statement about the Mississippi tax base. We are working to improve our education. I think the Education Reform Act of 1982, when fully implemented, will go a long way to addressing education in this State and that is the No. 1 need, the key to our State.

The other one is attracting industry and expanding our industry, but, as we know, nationwide industries are not opening in areas and Mississippi has been an area that has not attracted the big industries. We are looking at small businesses creating jobs.

We do administer the Job Training Partnership Act and we are trying to put those funds where they are needed to address the economically disadvantaged in this State and look at job training programs where it can directly lead into employment.

We are working on strategies toward economic progress in this State.

A project we began earlier on this year and we hope that we can begin to develop some concrete plans that will lead us toward economic progress. But we know that Mississippi cannot experience economic growth until we do something about boosting our education system in the State.

Mrs. ROUKEMA. Thank you.

Mr. PANETTA. Thank you, Mrs. Roukema.

I notice Mr. Sanders has come now and Mr. Sanders, if you have a statement to make, if you could keep it as brief as possible because we are running behind, you have that opportunity now.

STATEMENT OF ALIX H. SANDERS, SUPERVISOR, LEFLORE COUNTY, MS

Mr. SANDERS. In order to make it brief, I will deviate a bit from the statement which I submitted to your staff and I believe that you have with you.

Mr. PANETTA. Your statement will be made part of the record as it is, so you can summarize it.

Mr. SANDERS. Thank you.

Basically I am here as an elected official. I serve on the board of supervisors here. The board of supervisors is a basic unit of government in Mississippi and we feel that as an individual we have basic road management responsibilities, but as the budgeting agency for the county we oversee all of the other county agencies as they operate.

In doing that, we have occasion to observe the manner in which a number of programs operate in the county. Some of this is observed as a direct responsibility of an elected official other than my primary interest. On occasions I deal with most of the agencies in the county, including the schools, so I have had occasion to see how the food entitlement programs operate.

One of the observations I made recently was when I had occasion while repairing a road near a school to have me and my crew eat there and, as our responsibility, of a supervisor, we often have occasion to inspect and see the food in jails and there is a remarkable difference in those two programs either in the preparation and the presentation of that and I am concerned.

In the schools I believe—and I believe that it can be substantiated—that oftentimes though the entitlement programs are there, the children will simply take the tray, take one good look at what they have got and put it away and then eat snack food or junk food or what-have-you.

Now, I think that something has to be done to address that. I do not know whether that is a particular local problem, but that is a local observation. I do not know whether that is a compliment to the manner in which we have prisoners in this county, but in the end event there is a disparity and it does not go to the children.

Another thing that I have observed is in my particular interest in the administration of the Food Stamp Program here we were administering in a fashion that was not a credit to us all when I came onto the board.

The other four members that served with me decided to do something about that and in doing it we advanced the money to do renovations of the food stamp office only—with the understanding that the county would recoup some of the funds.

When we did that, we found out that we will get paid back but over a 40-year amortization schedule at about $190 a month.

Well, you are not going to induce counties in Mississippi to advance and improve conditions at the food stamp office if it is going to take you 20—well, we did get them to reduce that to 20 years, but if you are going to get 20 years to get your money back you are not going to put any money out there to have a waiting room or private interview room and that means that the manner in which people who receive food stamps and other entitlement programs are treated different from the rest of the populace.

We were doing it in the fashion that if you were interviewed in one segment the guy next to you was listening to all of your private information that you were relating in order to qualify. We have remedied that to some extent, but recently when I was visiting the food stamp office I had to peer over behind files that high [indicating] to see the workers and the reason for that is, they are trying every month to get everybody certified again and they can't handle it; that is all there is to it. They can't handle it, so as a result of that we are having difficulty—and people who would otherwise be entitled to receive benefits that they should be receiving.

To aid in my district, we recently decided that we would take part of the issuance of food stamps and put it 7 miles away in a small town called Itta Bena. We announced in the paper that this would be done, at least the food stamp people did, and when we showed up for Monday morning work at 6 a.m. on the day of issuing food stamps, the line was all the way around the barn. We had a thunderstorm at about 6:30 to 7:30 and people did not get out of the line. They stayed there.

Now, I realize that as a legislature measure, food stamps are not meant to get one person on there from month to month; it is a subsidy, but the reality of it is that there are people out there who depend upon it, people who receive it and when it runs out they are left to their own devices.

VOICES FROM AUDIENCE. Yeah.

Mr. SANDERS. I cited a simple instance of that in my testimony.

Now, what it all boils down to is what I heard you talk about a little bit here and that is jobs. Nobody here that I know of wants to go out to the food stamp office and stand in line all day. We want a job. We want to be able to earn a living and we want to be able to maintain our dignity.

Now, yes, we need education, but until we get it in Mississippi, we cannot have a populace that cannot negotiate their way through the benefit, so it has to be kept simple.

When it becomes a completed process that one must go through in order to obtain the entitlement then there is no need to have the entitlement. I understand the gross intent of Congress, but what I want you to see is the net result.

Now, I realize you can't see every instance and we can't talk about every specific case in the community, but if you can just remember basically for Mississippi, if you can keep it simple to the extent that we need it, do that and to the extent that you can alleviate it in terms of jobs, let's do that.

Thank you.

Mr. **Panetta**. Thank you, Mr. Sanders.

Responses to Questions for Alix H. Sanders

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. If there have been budget restrictions at the county level, how have they impacted on the management and operations of public assistance programs here in Leflore County?

Answer. No response received.

Question. In your prepared testimony, you cited ignorance to be the greatest enemy to a hunger-free society. Can you explain this in a little more detail?

Answer. No response received.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. Can you tell us what county programs are available to help feed the needy? What are the volunteer efforts? I know in my home State of Missouri the churches are very active with food distribution programs. They consider it a responsibility and frankly I agree with them. I don't mean to suggest that they would take the place of the Food Stamp Program—but they are there to help out with emergencies. What is happening here in Leflore County?

Answer. No response received.

Question. What kind of industry is in Feflore County? What changes have you seen over the past 5 years in the economy here in Leflore County?

Answer. No response received.

Question. From your perspective is Leflore County different from other counties in Mississippi with regard to living conditions or benefits available for the needy? Is it worse, better, the same as some neighboring counties?

Answer. No response received.

Question. Have conditions worsened over the past years? Can you compare conditions with a period of 10 years ago or 5 years ago?

Answer. No response received.

QUESTION SUBMITTED BY HON. WEBB FRANKLIN

Question. Many individuals have mentioned transportation as one of the barriers facing people desiring food assistance. Are there any Government agencies providing transportation in this county? If so, are they working adequately?

Answer. No response received.

[The prepared statement of Mr. Sanders appears at the conclusion of the hearing, see p. 96.]

Mr. **Panetta**. Mr. Fazio.

Mr. **Fazio**. I would just like to take two avenues of questioning.

Mr. Fraiser, you indicated that you had tried to get the Mississippi Legislature to increase the AFDC payment from that average of $96 a month. When was the last increase that took place?

Mr. **Fraiser**. I think it was back in 1975, 8 years ago. 1978. Excuse me.

Mr. **Fazio**. Does anybody know what the cost-of-living increase has been since then, offhand?

Mr. **Fraiser**. It is way up in the fifties.

Mr. **Fazio**. Like 50 percent?

Mr. **Fraiser**. Over 60, I believe. We were double-digit inflation just like everybody else until 2 years ago.

Mr. **Fazio**. So obviously that AFDC payment has been eroded tremendously in that timeframe?

Mr. **Fraiser**. Yes, sir.

Mr. **Fazio**. Why do you think there has been such a difficult time getting that kind of increase? Is there some disincentive the way the Federal law works?

Mr. **Fraiser**. Let me just——

Mr. **Fazio**. You know that law very well.

Mr. **Fraiser**. Part of it has to do with Mississippi's economy as we see it down here. Our two biggest income producers are sales tax and income tax. Those are both indexed closely with inflation. When inflation dropped, we lost a lot of resources as well and that put us in a tighter pinch than a lot of other States whose income base is a lot different.

I think it gets down to a question of priorities. I think that in trying to meet varied unlimited wants and needs with scarce resources that the State has made decisions to do other things and, like I said, I think we were treated very fairly but we didn't get what we asked for or what we needed.

Mr. **Fazio**. Apparently you pay at this point about one-third of the FDC standard of need at the State level. Is that correct, so the other two-thirds comes from the Federal level?

Mr. **Fraiser**. Yes, sir, it is more than that. 77.23 I think Federal, 23——

Mr. **Fazio**. So the more you hold down in State contribution, the more we pay as a percentage. Isn't that correct?

Mr. **Fraiser**. Basically it is.

Mr. **Fazio**. So there may be some instructive point to be made there.

I would like to ask Ms. Murphree one question. You spoke about the 30-page form. Mr. Sanders spoke about keeping it simple. What could we do?

You give us from the ground up practical experience here. What could we do to make that form something that would be more acceptable to the people who are now being excluded because they can't take the time or don't understand how to complete it?

Ms. **Murphree**. Well, the application form could be cut some. There is repetition in the application form and some of the things that are on there could be cut down and the language could be made simpler for people to understand.

Mr. **Fazio**. How much do you think you could eliminate, just as an estimate?

Ms. **Murphree**. Probably half of it.

Mr. **Fazio**. What about the monthly requirement?

Ms. **Murphree**. The monthly reporting—in Leflore County we have 1,200 cases that are monthly reporting, so that is 1,200 cases that my seven workers that I have right now have to do every month. They have to work budgets and do every month and that is a great deal—that takes—that is more——

Mr. **Fazio**. Do you have any suggestions as to how we can either shorten that or eliminate that periodical——

Ms. **Murphree**. The monthly reporting itself is not the problem. It is the staffing to do the monthly reporting.

Mr. **Fazio**. Thank you.

Mr. **Panetta**. We are running very tight. Unless someone has an urgent question they want to ask, I am going to move to the next panel.

Bill.

Mr. **Emerson**. I have several, Mr. Chairman, if I may.

First of all, I will try to make these quick.

Mr. Fraiser, I think we share your frustrations with the sometimes volumes of Federal regulations that have to be coped with.

Would there be any benefit in a block grant to the States and let you administer it? If we gave you a block grant we might add a little bit to it for what it cost to pay all these people to sit in Washington and write the regulations.

Mr. **Fraiser**. I guess my opinion is pretty much the same as that State counsel administrator at VWA. I think a lot of States have difficulty with the block grant, if it is going to be a transfer from the Federal level of the State on the cost of the program.

This is a problem that is national in nature and one that we can't afford at the State level and I think it would lead to a wide difference in the programs and not a uniform program nationwide if you would do that.

Certainly there are some advantages that could be gained and I take it that have been gained through block granting other areas, but you have got to look at the thing on the cost of it.

I think that is the bottom line of that particular issue.

Mr. **Emerson**. If our object is to get the best available help to the largest number of people, might there not be some benefit? We could work out the administrative problems.

I do not think we could just give you a block grant and say the Feds have been giving you these regulations under which you have to live all the time.

I think there would have to be some uniformity, but I think maybe some adjustments could be made there.

I tend to think that at the State level very often administration can be handled with greater facility, can be less cumbersome and thereby enable States to get the help to the people who really need it in a more expeditious and perhaps in a more targeted manner.

Mr. **Fraiser**. The theory behind it is all well and good. I think, to my way of thinking though, more benefits could be obtained by looking at some of the corrections that I have already mentioned to you: Mail issuance, monthly reporting, uniformity between Federal Government programs that would have better benefits.

Mr. **Emerson**. That is a good point there.

Ms. Hogan, many Governors have set up commissions to insure the needs of their citizens are evaluated and met through both Government programs and volunteer efforts. What has Mississippi done in this regard?

I am particularly curious as to what the level of volunteer activities has been. I mentioned in my opening statement the fact that there is some $60 billion in private, charitable help in the United States on an annual basis. How does that stack up to Mississippi?

Ms. **Hogan**. Our private nonprofit organizations do get involved, but you have to remember the state of economy and people who donate to private nonprofit organizations, their contributions are down.

We have some 500 or more boards and commissions operating in the State looking at our programs and the people on those boards are volunteers.

We believe strongly, and I will go back to my statement, that we have to have partnerships between business and private nonprofit organizations and we are building on that.

We do recognize that the time has come that Government does not have all the answers, but Government should still continue to be responsive and responsible to get people involved.

Mr. EMERSON. In Mississippi does the Governor have a coordinating council? Does he actively address this?

Ms. HOGAN. Yes, he does. Yes.

Mr. EMERSON. Are there, in Mississippi, any education programs in the public schools about nutrition?

Ms. HOGAN. Yes, we do have some programs.

Mr. EMERSON. Is this fairly universal? In elementary school does every school child have a good understanding of what nutrition is all about and, if not, could that be made a part of the curriculum?

Ms. HOGAN. I am sure it could be made a part of the curriculum, but I think that the Department of Education does administer programs not only in the public schools, in some of the Head Start Centers and day care facilities throughout the State. They make nutrition education a part of the curriculums and try to introduce the children to balanced meals and importance of adequate diet and nutrition.

Mr. EMERSON. From what I see of the relationship of hunger and nutrition, I think that education is one of the most crying needs of all in the whole spectrum of the problem.

Just a couple more quick ones, if I may, Mr. Chairman.

Mr. PANETTA. Make it quick.

Mr. EMERSON. The monthly reporting and retrospective budgeting provisions of the Food Stamp Program apply to about 70 percent of the participants in Mississippi and nationwide they apply to about 20 percent. Why does Mississippi include so many people in this provision?

Mr. FRAISER. OK. First of all, it is about 35 percent and from my understanding that is the highest in the Nation.

Other States in the Southeast have as low as 8 to 10 percent. The only thing we can say about that is right now we have got waivers in trying to get that level down. Those have not been approved.

The southeast region of F&S has approved our plan and that was all they would approve at the time, so we are in the process of trying, through the waiver process, to reduce the caseload.

However, I think this is going to be very difficult.

The justification that is required to do that, even though other States might have been the—as you might not—I guess you would not know unless you have been here. Our Food Stamp Program in Mississippi is on a totally manual basis right now. We just cannot do a lot of the computer work and programs that might give us better data to base the justifications on. We have a process right now that is sort of a pioneering effort in the works but it is not helping us right now.

Mr. EMERSON. I would like to pursue this line of questioning, but we will do so in writing with Mr. Fraiser.

As the chairman knows, I am interested in monthly reporting and retrospective budgeting and I would like to pursue this if I may.

Mr. FRAISER. Yes, sir; I will be glad to.

Mr. PANETTA. Thank you very much, Mr. Emerson.

If the other panelists do not mind, I would like to go to the next panel and I will start the questions with the others, unless you have an urgent question that you would like to address to this panel.

Mr. **Morrison**. Mr. Chairman, I would just like to make a suggestion.

While your legislature is considering tax reform, and I know you have got a number of problems and we are very enthusiastic about your new kindergarten program, we hope you can get that going. But they might consider the fact that you are in essence taking approximately 6 percent of the purchasing power of food stamps away from these people in this audience by applying your State sales tax to food stamp purchases.

Most States do not do it. That is one way that you could give more—make more money, more purchases available for the same number of stamps to these people.

Thank you, Mr. Chairman.

Mr. **Panetta**. Mr. Smith.

Mr. **Smith**. No.

Mr. **Panetta**. Mr. Franklin.

Mr. **Franklin**. No.

Mr. **Panetta**. OK. Thank you all very much. I appreciate your coming here and presenting your testimony. It has been very helpful to us.

The next panel is on health and nutrition: Dr. Alfio Rausa, who is director of Leflore County Health Department, accompanied by Winn Keahy, Diane Pickens, and Gail Moore; Dr. Jim Robbins, who is chief of staff of the Greenwood-Leflore Hospital; Dr. Aaron Shirley, who is director of Jackson-Hinds Comprehensive Health Center in Jackson, MS; Agnes Hinton, who is nutrition service director of the bureau of personal health in the Mississippi State Department of Public Health. If you would take your positions at the table.

Dr. Rausa—if I could have your attention, please, so that we could proceed—the next witness will be Dr. Rausa, who is director of Leflore County Health Department.

Dr. Rausa, you can proceed.

STATEMENT OF ALFIO RAUSA, M.D., DIRECTOR, LEFLORE COUNTY HEALTH DEPARTMENT, ACCOMPANIED BY WINN KEAHY, DIANE PICKENS, AND GAIL MOORE

Mr. **Rausa**. I am Dr. Rausa, and I am health officer for the State of Mississippi. I have lived in this community for 16 of the last 18 years. The health department has been involved in providing health services. We started with a high infant mortality. Half of our births were outside the hospital when I arrived here. The housing in the community was about 60 percent with dilapidated houses below any minimum standard. We have come a long way and yet fallen apparently further behind the rest of the State.

Over the years, I have been through a potpourri of programs. I started out with county help planning, section 314(e) money, went on the REP, improved emergency outcome, Improved Child Health Program, WIC, and all these programs have had a major factor in improving the health status of our people. We enjoyed some flexibility in the way we have been able to implement the programs. The outcome of the programs in some ways is not still—is not in the statistics. There are subtle changes that you sort of have to live here to see.

When I first arrived here, you could not open a child's mouth for an examination that you would not see a large number of missing, decaying or filled teeth, and very few filled teeth, unfortunately. Through the medicaid screening program, we could do early screening and we could refer them to the doctor, but that didn't have that big an impact.

What I noticed with our screening program—when we first started the EPSET some 10 years ago, to almost every child we handed a referral. It was almost automatic; take it to the dentist and get some correction. There were some limitations as to how much could be spent. It has amazed me that in the 7 years that we have been in WIC, the rapid decline in dental pathology.

We don't have fluoride in our water here, so what is it? These children are still coming from poverty, and I attribute it to the single factor of WIC, giving protein at an early age right after conception, or as soon thereafter as possible, and continuing through the first few years of formative life in changing that substrength of those teeth. The quantity of goodies, sugar, that is available and that is marketed is increasing, so it is not that the children are not exposed to the things that attack teeth; it is that they now have a solid foundation on which they can fight off that tooth decay.

We have an ongoing activity that hasn't really been fruitful yet. Yes; there is a School Lunch Program, but my concern with the School Lunch Program, as Ms. Sanders has mentioned earlier—you can get a better, appetizing meal at the jail here, the Leflore County jail, than you can in the lunchroom. We may have a balanced meal on paper, but when you allow catsup or pickles to serve as a second vegetable, that is unacceptable.

Mrs. ROUKEMA. Excuse me, Mr. Chairman. Dr. Rausa, you are not suggesting that that is being served in your local schools, are you?

Mr. RAUSA. Yes; as USDA approved.

Mrs. ROUKEMA. No. Well, that is contrary to the laws of Congress and what the regulations were that the USDA imposed after the outcry from both the public and the Education and Labor Committee. And if that is happening in this county, it should stop immediately. No; it never did go into effect, and I don't know why it should be conducted here.

Mr. PANETTA. As Mrs. Roukema points out, those were proposed regulations that never actually went into effect because of the opposition that was developed.

Go ahead. Proceed.

Mr. RAUSA. To continue, on the School Lunch Programs, there was some innovative data. The couple of years that I was missing from here, I was down on the Mexican border in South Texas working with the migrants, and in that area they had some innovative approaches to trying to get the food culturally acceptable to the people.

One of the problems that I see in the WIC Program is that, yes, we have a balanced meal, but it is not a meal that is culturally acceptable to the people. So we have a nutritionist and nutrition aides trying to change these people's lifestyles, and they need some changes. They are high-caloric diets and there are some specific nutrients, but I think if we could identify some foods that are culturally acceptable and incorporate them into the WIC package, then we can still achieve the addition of those nutrients to their diet and have a dramatic effect on not only the participation but their acceptance of the food.

The program here, by the way, we have about 68 percent of the eligibles in Leflore County participating in WIC, which is probably one of the highest in the whole United States, and I have seen the subtle change in their teeth. I have seen in our well-baby clinics teenagers that used to produce 5- or 4-pound babies now producing 8- and 9-pound babies because they are on WIC earlier.

The statistics are not in in that there is still—if you look at the total number of low-birth-weight babies, we have not changed that much over the last—they are running around 10 percent, 11 percent, 12 percent. When you are dealing with small numbers, one or two low-birth-weight babies can throw your statistics way off. But in observations in the clinic, we are seeing the WIC participants are producing large babies, which is no surprising shock. If you feed a pregnant woman, she will produce a healthy live baby, and that baby will survive better in the future.

The innovation that we may have here, at least when I was talking to some of the staff members, our WIC clinic practically from the beginning—there is no such thing as a WIC clinic. What we do is have health services and integrate—we try to have an integrated health service, and WIC is a resource which we have in our pocket in order to address a particular health problem—in this particular instance, the lack of proper nutrition—and our clients come to the health department less frequently and get more services.

The one disadvantage of WIC, if there is such, has been in my outlying clinics. We have had in our district many clinics in the small towns out in the community. Now I will not say that WIC was the sole cause of the demise of the clinic—it was shifting populations. But when we brought WIC on and the administrative moneys were not there to provide transportation for the food to the clinic site where we did the certification, it did not take these people long to say, well, you know, "If I go to Greenwood, I can get my clinic visit and my food in one trip and do some shopping, too," and it has led to the demise of health services being available nearby.

I do not know whether at this point it would help us in this particular community to try a transportation program of delivering the food to the clinic site near their residence. I know it has improved our attendance at our clinics. We had set a target population of—125 percent of poverty is our target population. There are about 850 to 900 pregnant women in this county. Some 700 come to the health department for clinic services. And, in our district here, which is nine counties from the delta to the hills, some 4,400 of the 6,000 women are attending prenatal clinics at the health department. Somewhere we will provide you with the specific numbers of women, infants and children that are participating in our county.

The other item that I would like to speak to is the aged population. The nutrition sites here, which I believe you visited the one in Itta Bena—and there are two in town—are adequate in the sense that they are large enough to accommodate the group of people. And there is some transportation available for the people to attend. The problem that comes up is that it is not sufficient in slots available, and the bigger problem is that we do not have a Meals on Wheels Program here because of limitations at the State level.

We, in the health department, have a home health program and identify some people in the community that are bed-bound receiving home health services, professional services, and yet there is no vehicle to get them food. And this has to be negotiated by a social worker, as one of my members here on the staff was, or some other community group. And if there is some leftover food—somebody does not show up in the kitchen—we will put it in a container, give it to the bus driver, and as they head that way just detour past the house, but you have to wait for some leftover food.

What we need is an expansion of the Meals on Wheels Program in a rural area where transportation is a problem and where we have a lot—a growing percent of elderly who are in need of proper nutrition. We are willing to spend tens of thousands of dollars for medicaid and medicare to repair a broken hip rather than to provide some calcium to prevent those bones from becoming brittle.

In closing, if I had my rathers, I would definitely continue the WIC Program and expand it. I am really remiss at John Barr. He didn't tell me we were going to try to carve out some money. The jobs bill that you all passed a couple of years ago brought us an opportunity to expand. That is the last time he tried to raid my treasury, and I hope you all go home and put some money in the pot because John could have a hard time getting my slots.

Anyway, the Meals on Wheels Program I would like to see expanded, and I would like to see in the WIC Program—one of our problems is that I would have five nutrition slots, not all here in Leflore County, but it is very difficult in a rural area to get all of our people to come and work at low wages. So we are dependent on our nutrition component education on our nurses, who have everything else to do, and we have used some of our nutrition aides or some of the aides to function as nutrition aides to try to put on some demonstrations.

One thing that I could see happening both in WIC and in the Food Stamp Program is have some kind of an ombudsperson that could assist targeted people that have this problem of negotiating the system. When we implemented social services, it is amazing how many doors opened up in our community because we had one lady that found out and kept up with all of the little closets of money. There are civic clubs that have funds. There are specific target agencies that have funds. And there are other people that have money that don't know what to do with it. And it is amazing, once you put somebody on their tail, what can be accomplished.

We need some funds to support that kind of a person, I believe, in helping people to shop, use their food stamps more wisely, how to stretch it to the end of the month. At the same time, I still, you know, support the statements made earlier, though we do need an expansion of the funds available in the total package.

My last statement has to deal with nutrition in the schools. It is good that we are starting to see the implementation of nutrition education in the schools, but we have got to improve the nutrition that is put on the plate. It should be not only balanced on paper, but it should be to where it is appealing to the child. And in this county I know we have about 80 percent of our children participating in the food program, but it needs to be expanded. When you have 30 percent of your community, almost 40 percent, in poverty, we do not have the resources.

What has amazed me in the years that I have been here—and that is why I am still here, probably—is how much has been committed by this county to its services, and we have made fantastic strides. We have industries and jobs, and we have got to go, it seems like miles more, even to catch up to the last State, even though we have made these fantastic strides.

I have with me Diane Pickens, Ms. Gail Moore. Diane is our social worker. Ms. Moore is the nurse midwife and works with our Maternity Child Health Program. And Ms. Keahy, on the end. They will be available to answer questions at the end.

Mr. PANETTA. Thank you, Dr. Rausa.

RESPONSES TO QUESTIONS FOR ALFIO RAUSA, M.D.

QUESTIONS SUBMITTED BY HON. MARGE ROUKEMA

Question. What family planning programs are available statewide and in Leflore County?

Answer. No response received.

Question. Specifically, what are the range of services available for all age groups?

Answer. No response received.

Question. How are potential participants made aware of these programs?

Answer. No response received.

Question. Do you believe that an increase in family planning programs would be beneficial for Leflore County?

Answer. No response received.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. Dr. Rausa, earlier this year a subcommittee on which I serve had a hearing at which a representative from the Centers for Disease Control testified concerning the pediatric nutrition surveillance system. I realize that the State of Mississippi has only recently become a part of that system. Nevertheless, according to the physician the CDC data, which represents results of initial screening evaluations for infants and children—before they begin to receive WIC benefits, or other types of benefits a modest improvement in the nutritional status of children, especially those under 2 years, has been shown.

Would you comment on this and tell me if you have seen the same improvement in Leflore County?

Answer. No response received.

Question. Earlier this year the Greenwood newspaper had a series of articles on hunger. You, I believe were one of several people interviewed and stated that the WIC Program has resulted in a dramatic decrease in infant mortality and in the number of low birth weight babies. That is good. However, can you tell us what steps you are taking to improve these rates even more?

Answer. No response received.

Question. What are the reasons that Mississippi, while showing improvement, still has one of the highest infant mortality rates in the United States? Will you discuss the family planning efforts you have instituted. This article I mentioned also stated that: "A stepped up family planning effort is also paying off, with fewer teenage pregnancies. Teens are statistically more likely to have low birth weight babies, who are more likely to have medical problems. How there are fewer teens giving birth, and those who do are less likely to have small babies."

Answer. No response received.

Question. What kind of nutrition education programs do you operate? Are you familiar with the Expanded Food and Nutrition Education Program, EFNEP, operated by the Cooperative Extension Service? Can you comment on this?

Answer. No response received.

Mr. PANETTA. Mr. Robbins.

STATEMENT OF JAMES ROBBINS III, M.D., CHIEF OF STAFF, GREENWOOD-LEFLORE HOSPITAL

Mr. ROBBINS. I was asked to speak to this committee in my capacity as chief of staff of the Greenwood-Leflore Hospital. The hospital is a full-service general hospital with 230 beds and 25 bassinets. There are 37 physicians on the active medical staff, and these include all the physicians in active practice in Leflore County except for one. The physicians in our community see the full spectrum of patients in the community. All of the physicians see medicaid and charity patients, as needed. No one excludes any portion of the community.

I am a urologist, which means that I limit my practice to disorders of the urinary tract and the male genital system. My specialty limits considerably my professional exposure to problems of hunger. The medical manifestations of malnutrition would ordinarily be seen by the primary care physicians, especially the pediatricians and family practitioners. My testimony is based on conversations with the other members of the medical staff and on a review of the records of those patients discharged from the hospital with a diagnosis of malnutrition or of failure to thrive.

Since October 1983, we do have computer access available because of the DRG Program that you all have helped us with, and there have been 8,775 patients discharged from the hospital. Of these, seven patients have one of those two diagnoses. One of the patients was a 47-year-old female with terminal lung cancer and was not germane to this testimony. Of the other six, three were children 5 months old or younger, and the other three were quite elderly, aged 78, 80, and 85. The three children were malnourished, not because formula was unavailable in the home. The WIC Program, as everybody said, has really taken care of that to all intents and purposes. In two cases, malnutrition resulted from maternal neglect, and in one case it was the result of milk protein intolerance. One of the neglected children died after transfer to the children's intensive care unit in Memphis, at Le Bonheur Hospital. The other two did well in the hospital with proper feeding techniques and were discharged with social service and health department followup. There are generally 8 to 10 children per year seen with this problem, serious malnutrition requiring hospitalization, and I am told that once the home situation is improved, they almost always do well from that point on.

The three elderly patients had problems similar to those of the children. One was a nursing home resident who refused food because of senility. One was an elderly lady who broke her hip. When she went home after hospitalization, she was probably discharged too soon, and she just really was not strong enough to make it alone and was readmitted with the malnutrition. She was rehospitalized until she became stronger, and did well following her next discharge. The last patient lived with his daughter and he said on admission that she just wouldn't feed him. He was discharged to a nursing home following his hospitalization.

The primary care physicians in Greenwood tell me that 15 years ago hunger was a real problem throughout the delta. They say that they saw many children and many adults who were obviously malnourished, especially in the winter. They saw young children with severe anemia and with edema secondary to lack of dietary protein—children like you see in the movies in Africa and South America; just severe starvation. The infant mortality rate was much higher and the childhood death rate was much higher than it is today due to diseases associated with malnutrition.

These physicians state that they no longer see these diseases at all. The six hospitalized patients cited above are a small sample, but they are illustrative, I believe, of the problem which remains. Hunger, to the degree that a medical condition—malnutrition—results, is limited in our community to the extremes of age and then almost always is the result of ignorance or neglect.

During the periods of very early childhood and advanced age, the human body is quite fragile and improper nutrition can have severe effects. At other times, the human body is a wonderfully resilient machine and it runs on almost any fuel requiring relatively severe dietary abuse to produce disease.

The infants that the pediatricians see with nutritional problems are almost always the result of teenage pregnancies in the economically deprived population. Children born into stable families with both a mother and a father in the home almost never have problems of this kind. It would seem that an effort to reduce the rate of teenage pregnancies would be a most effective means of attacking this problem.

As others have mentioned, there also seems to be a lack of basic nutritional knowledge in the population, especially again in the economically deprived segment of the population, and an effort in this direction may be helpful. I think, having listened to what some of the other people have said, that the effort need not just be in the schools but perhaps some consideration can be given to including some type of educational program, and maybe there already is, in the Food Stamp Distribution Program, et cetera.

I am not telling this committee that there is no hunger in Leflore County. You have seen that there is. I am confident, however, that hunger is no longer the problem that it was several years ago. The severe diseases resulting from hunger—really starvation, not just hunger—are rarely seen and then only in the limited circumstances I have described. Less severe disorders resulting from hunger may exist, but these disorders are subtle and have other causes, apart from hunger. There is no data which would permit me to make a statement regarding these more subtle things.

If the committee would like to know whether these more subtle medical conditions exist and whether they can be correlated with the diet of the affected individuals, I believe you can get this data, but it will require significant investigative effort to get it. The medical community here in Greenwood stands ready to participate, if you would like.

I was instructed by our hospital medical staff at our last meeting to tell you all that we appreciate your interest in our community and that we are anxious to help you in any way we can.

Responses to Questions for James Robbins III, M.D.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. Dr. Robbins, I am interested in your statement in which you describe the improvement over the past several years in the problem of malnutrition and medical problems. I agree we must continue programs to help the needy—such as food stamps and other assistance programs—and reinforce our current nutrition education efforts. Would you care to expand on this thought?

Answer. The first question is somewhat general and my answer will also have to be somewhat general. I would suggest that any problems we have in our community with nutrition are secondary to the real problem in the community and that is poverty. I believe that programs to distribute food and even programs to promote nutrition education may be helpful in relieving the symptoms, but the eventual cure for the trouble lies in improving the overall economic health of the community. I believe this can best be obtained by improving educational standards. We are attempting to do this on both a local and a State level. We have growing community support for the local public school system. Both the black community and white community are gradually coming together in this area. We have a long way to go but we have at least made a beginning. I am not sure what is the role of the Federal Government in education, but I am convinced that the proper preparation of our children is vital. They must be able to compete for the jobs which are presently available. More importantly they just must be prepared for the jobs which will be available in the future. At present we are hampered in industrial recruiting for our community by educational limitations in our work force.

Question. Is medical care available for the poor here in Leflore County. You state that over the past 8 months almost 9,000 patients were discharged and 6 had problems related to malnutrition. Are there medical problems for children and the elderly that do not require hospitalization and yet still result in malnutrition? Please explain.

Answer. The second question has two parts. First, the answer is a definite yes. Patients are admitted to the hospital here in Greenwood totally without regard to their ability to pay. The physicians in our community see patients in their offices on the same basis. Obviously financial factors do limit the physician's options in some cases, but necessary medical care is made available.

Second, Dr. Aaron Shirley in his testimony before the committee stated that these problems do exist. I believe he is probably correct. I cannot make a stronger statement than this because there is no data available in our community to connect nutritional status with these more subtle medical problems. In my letter to your committee dated June 25 I suggested how this data could be gathered. I have enclosed a copy of that letter.

[Letter referred to follows:]

Greenwood Urology Clinics, P.A.,
Greenwood, MS, June 25, 1984.

Select Committee on Hunger,
House Annex 2, Room 507,
Washington, DC.

Attn.: Ms. Vivian Gabor.

Dear Ms. Gabor: Enclosed is the typed record of my testimony before your committee. I have also enclosed copies of some of the hospital documents from the six patients I discussed.

One of the members of the committee, I believe it was Representative Panetta, stated that data regarding the more subtle medical manifestations of malnutrition would be very desirable to the committee. Let me repeat the willingness of the medical community here in Greenwood to assist in gathering this data.

In order to gather this data it will be necessary for the committee to assign someone experienced in investigating medical statistics. It will require the setting up of a prospective study and I expect it would require the cooperation of the pediatricians, the family practitioners, and the Health Department. I feel certain that all of these people would be glad to make their records available and to participate in the study. Please understand that we locally have neither the necessary expertise nor the facilities to design the study or to properly collate the data. Both Dr. Rausa and I would be glad to discuss this further with your committee.

I appreciate the opportunity to discuss these problems with the Select Committee on Hunger. Please let me know what further service I can provide.

Sincerely,

JAMES S. ROBBINS, M.D.,
Chief of Staff, Greenwood-Leflore Hospital.

NOTE.—Hospital documents referred to above retained in subcommittee files.

Question. Are you aware of any nutrition education programs in the public schools in Mississippi?

Answer. The best person to answer this question is Mrs. Jo Ann Walton. She is the administrative assistant for instruction and personnel for the Greenwood Public Schools. Unfortunately she is out of town this week. I have spoken with others in the administrative office, and I understand that there is a mandatory 4-week block of instruction in the fourth grade on health and nutrition. There is an additional mandatory block of instruction in the seventh grade. In high school, nutrition education seems to be limited to elective courses such as home economics and some of the vocational courses such as cooking. If more detailed information regarding this subject is needed, I would suggest that you get in touch with Mrs. Walton.

[The prepared statement of Mr. Robbins appears at the conclusion of the hearing, see p. 97.]

Mr. PANETTA. Thank you, Dr. Robbins.

Dr. Shirley.

STATEMENT OF AARON SHIRLEY, M.D., DIRECTOR, JACKSON-HINDS COMPREHENSIVE HEALTH CENTER

Mr. SHIRLEY. Thank you, members of the panel. My name is Aaron Shirley. I am a practicing pediatrician and project director of the Jackson-Hinds Comprehensive Health Center in Jackson. I also serve as chairman of the board of trustees of the Mississippi Medical and Surgical Association, which is an affiliate of the National Medical Association. I appreciate this opportunity to come before you to share my views on the problems of hunger and malnutrition in our Nation.

I am sure you are familiar with the Field Foundations Survey of Hunger in the United States in 1967, with a followup study 10 years later. I had the opportunity to participate in these surveys and was also part of a team which visited this area in April and May of this year.

My firsthand experience with nutritional problems of the poor is not limited to the few weeks spent during these studies, however. Mine is an everyday experience as we provide a wide range of health and health-related services to more than 26,000 poor in the city of Jackson and surrounding Hinds County, including WIC certification and nutritional counseling to 5,000 poor pregnant women, infants, and children.

In 1967, when we examined children in this very town and outlying rural communities, we saw many children on the verge of actual starvation. They were stunted in their growth and development, dull, and with very little vigor, as you would expect of a 3-, 4-, or 5-year-old child. Ten years later, and again in April and May of this year, we found similar conditions, but not to the extent to which they existed in 1967.

It cannot be denied that the overriding factor contributing to the improvements which we did see has been due to the combined benefits of the various food assistance programs put into place during the past decade. This is not to say or to imply that poverty-related hunger and malnutrition no longer exist. It does exist. It is still widespread among the poor of our State, with children and the elderly being particularly affected. With the absolute number of individuals in poverty growing, the problems are sure to deteriorate, and without appropriate intervention we may soon find ourselves back to the conditions of 1967 and the numbers adversely affected in this State would be high.

For instance, there are 425,000 children participating in the School Lunch Program. Of these, 290,000, or 68 percent, receive their meals free or at reduced price, meaning they are from families in poverty. When we consider that poor children obtain one-third or one-half of their daily nutrients from school lunch, we can readily see the potential negative impact of those who may no longer be able to afford these meals due to cutbacks and changes in eligibility requirements.

Some might argue that the difference will be made up at home. This is just not the case. From our own firsthand experience, we find that 70 percent of the 5,000 individuals, mostly children, which we certify annually for the WIC Program, have dietary—home dietary—histories deficient in vitamin A and vitamin C. Forty-five percent are deficient in iron, and 30 percent in protein. In those children 3 to 5 years of age, 15 percent are deficient in calcium. And, as we interviewed family after family recently and looked in their refrigerators and on their pantry shelves toward the end of the month, we could easily determine the reason—not enough food.

Over past months, there appears to have developed a controversy over this issue of hunger and malnutrition in our country. It is my understanding that even your being here today trying to sift out the facts has provoked some degree of resentment and suspicion on the part of local officials. I can tell you, over the years this has been a predictable reaction of those who have consistently ignored the problems of poor people and have fought hard to retain a political and economic system which perpetuates poverty and all that living without an adequate income implies—poor housing, malnutrition, ill health, and shortened lifespan.

You have seen some of this for yourselves as you visited families in this area. I hope that you will keep in mind as you observe these families that the hunger that they speak of is not the occasional discomfort that you might experience on a busy day in which you might miss a lunch or some meal; the hunger which you see here is ongoing and leads to chronic malnutrition. And the consequences of this malnutrition takes its toll—as pointed out in the attached publication from the March 1983 Pediatric Annals, which is a professional medical journal—pointed out in this article is clear-cut evidence of a synergistic relationship between nutrition and infection. A rather common occurrence of diarrhea, measles, respiratory tract infections, are of minor consequence in a well-nourished child, but can be deadly in those children experiencing chronic malnutrition.

I would like to offer a word of caution on how you interpret some of the statements made by the local chief of staff. Much is made of the discharge diagnosis of patients over a period of years. A closer look, not so much at discharge diagnosis but of records of those children who may have died from complications of pneumonia, dysentery, measles, might be more revealing—complications which came about because these children's body defenses had been compromised by chronic malnutrition and undernutrition. And these states of malnutrition have been brought about not by ignorance and neglect but by inadequate food, not enough food.

Now, grant you, the death certificate of these children will state pneumonia as the official cause of death; however, chronic malnutrition is the real culprit.

Members of the panel, in closing I ask that you give serious consideration to immediately increasing the amount of funds for the various nutrition support programs, all of them—food stamps, WIC, school breakfast, and school lunch. I say increase them all because it is obvious to many of us that one meal, or even a portion of a meal, can make a difference between a child who is healthy, happy, and capable of learning and developing into a productive citizen, and one who is hungry and malnourished, apathetic, and vulnerable to sickness and disease and possibly a shortened lifespan.

Thank you very much.

Responses to Questions for Aaron Shirley, M.D.

QUESTIONS SUBMITTED BY HON. MARGE ROUKEMA

Question. From your knowledge of the range of services offered at State and county levels, what is your view of the role of family planning programs in combatting hunger and poverty?

Follow-up. Would you recommend any changes in family planning programs currently underway in Mississippi?

Answer. I see the family planning programs as an excellent vehicle for outreach and education. Outreach in the sense of identifying individuals in the childbearing age group who are at risk for malnutrition and who may have small children at risk or elderly grandparents at risk and who could transmit information into their communities about the availability of programs aimed at preventing hunger and malnutrition. From the standpoint of education, the family planning programs could be used as a tool in job counseling, career opportunities and appropriate decisionmaking about delaying pregnancy and limiting the number of children to coincide with the financial resources and career goals.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. Dr. Shirley, thank you for coming to our hearing. You, I believe, are the one physician that has been on the three hunger trips to Mississippi in 1967, 1977, and 1984. You have said that the overriding factor contributing to the improved nutritional status is due to the various nutrition programs. I assume this is true for the children receiving benefits, such as WIC and food stamps. What about the children not receiving benefits. Why don't these families get help? What can be done to get these people in to apply for food stamps?

Answer. There are a number of factors responsible for certain needy individuals and families not receiving WIC, food stamps, and other food assistance benefits. In the area which you visited, the Mississippi Delta, we have found the major problems to be the following:

A. Transportation—Many eligible persons must travel up to 40 miles round trip to pick up food stamps or WIC commodities. Most do not have their own transportation and thus must pay a neighbor or a friend to transport them. Being poor, they cannot afford to pay $12 to $15 for a trip that would sometimes result in only $40 to $50 worth of stamps

B. Attitude of Food Stamp Administrators—The manner in which the program is administered in Leflore and Holmes Counties can be one of the most humiliating and demeaning experiences imaginable.

There is constant questioning of young Black female food stamp applicants of their sex life. Neighbors are encouraged to inform food stamp workers if female recipients have male visitors. In Holmes County there have been numerous cases of apparent selective prosecution for supposedly food stamp fraud. This has served to intimidate many truly eligible elderly persons from applying.

C. Lack of Outreach—Many families and individuals either do not know about the programs or do not understand how to obtain benefits. In areas where the programs actively seek out the needy and assist them in the application process, the participation is much greater.

Question. After the physicians task force came to Alabama and Mississippi one of the members described the people in those States as "hanging on the thin line between hunger and starvation" and stated "Some of the counties we saw in Mississippi and South Alabama are on a par with the Third World." Do you agree? If so please describe some of the medical conditions that are the same. If not what are the medical problems you have seen?

Answer. I have not personally had the opportunity to visit the Third World counties referenced in those remarks so I cannot make the comparison. What I can tell you is this. Twenty-five percent of children we see in our clinic for the first time whose families are not receiving food assistance benefits are anemic whereas only 3 to 5 percent of those who are receiving benefits are anemic. Dietary histories taken from these families clearly indicate deficiencies in basic vitamins and nutrients. This coupled with the documented anemia is clear cut evidence of chronic malnutrition. It has been clearly documented that chronic malnutrition leads to weakening of the body's defenses against infectious diseases and too many of these children which we see have had repeated bouts of pneumonia, middle ear infections, infectious diarrhea, and so forth. A good number die from these conditions. Whereas they do not die from actual starvation, they do die as a result of chronic malnutrition. So a child who dies as a result of chronic malnutrition is just as dead as a Third World child who starves outright. So to me personally, I am just as outraged.

Question. Dr. Shirley, you imply in your statement that controversy over hunger and malnutrition means that people are trying to deny it exists. I agree there is controversy—however, I will tell you I do not believe that we have hunger in our country like that of the Third World countries. I believe our main problem is getting people to apply for these benefits and then educating them on how to use the benefits. Would you care to comment?

Answer. I agree that one of our main problems is the lack of outreach and education. Please note my comments on questions one and two.

[The prepared statement of Mr. Shirley appears at the conclusion of the hearing, see p. 98.]

Mr. PANETTA. Thank you very much.

This is Ms. Hinton, who is the nutrition services director for the Bureau of Personal Health, Mississippi.

STATEMENT OF AGNES HINTON, NUTRITION SERVICES DIRECTOR, MISSISSIPPI STATE DEPARTMENT OF HEALTH

Ms. HINTON. Thank you.

In that capacity, I do provide technical supervision to 4 nutritionists at the State level, 9 district nutritionists, and Ms. Keahy is one of those, and 68 full-time equivalent local nutritionists. Eleven of these local nutritionists are funded by our department, but work in independent health agencies such as Dr. Shirley's.

Unlike many State agencies, our department provides direct health services for our citizens, including the areas of maternity, family planning, infant and child health, chronic disease, and communicable disease through health departments located in each of our counties, with larger counties providing multiple sites. Nutrition counseling by nutritionists, nurse practitioners, nurses, and physicians is an important component of many public health programs and certainly is an essential part of any medical service in order to assure appropriate outcome. Our department's involvement with direct food assistance is mainly through the WIC Program, through referral of patients for programs such as food stamps or community action agencies and food protection at public feeding sites.

This year, all the States in our region were asked to provide information to our regional HHS office regarding pockets of hunger. Our efforts to compile this information were directed through State, district, and local nutritionists, physicians, social workers, nurse practitioners, and nurses. We found little concrete comprehensive data on which to base estimates of need, although certainly there were many individual reports of hungry people, as well as reports from social service agencies of increased need for food assistance.

Waiting lists for services were noted in a number of congregate and home-delivered meal programs for the elderly. Transportation to access available services is clearly a problem in many areas of the State, such as this one. Special needs, such as the elderly on sodium-restricted or diabetic diets, may prevent individuals from receiving assistance from current programs. In other words, they just don't have the staff to meet those special needs. The greatest needs in many areas, including the delta, appear to occur among the elderly population.

While we felt that our information was not really adequate to give a comprehensive assessment of the situation, our general consensus was that many people are better nourished than they were 10 to 15 years ago, but this was largely due to Federal food assistance programs such as WIC, food stamps, and child nutrition programs. Many of our citizens live a marginal day-to-day existence dependent mainly on public assistance, food stamps, food pantries or congregate feeding sites, and on programs such as WIC for their food intake. I would like to emphasize the absolute necessity that these programs be maintained and, in some instances, expanded or modified to better meet these critical human needs.

You have heard Mr. Barr describe our WIC Program. We have found WIC to be an important adjunct to health services and feel its effectiveness has been largely due to its integration into our agency's health care, as you heard Dr. Rausa describe. One of the main strengths of WIC is the provision of nutrition assessment and education along with food supplements tailored for the individual patient. Changes in attitude, food habits, and food purchasing habits resulting from the nutrition education may affect the entire family's health for many years.

We need to expand this focus on nutrition education to other food assistance programs such as food stamps. I am pleased to see such a component for food stamps included in H.R. 5151, which Mr. Panetta has alluded to. I do want to encourage through that provision not be diluted—as I understand it has already been cut in half—and it needs to be left strong enough to really do some good.

While we do feel that WIC is an effective program, it is not a panacea for all the people who need food assistance in Mississippi. WIC is limited to specific target groups and is a food supplement only. Transportation barriers prevent some eligible participants from fully participating in the program. There are program restrictions, such as the limit of 8 pounds of special formula per month, which prevents special needs of some participants from being fully met.

Our specific recommendations for this committee in dealing with the complex problems of hunger: First, we would like to see continued strong funding for WIC, and we would like to see it on a steady basis. Mr. Barr alluded a little bit to some of the problems caused by the ebb and flow of funding. Certainly at the local level for our participants and for our staff trying to cope with this, the numbers game becomes a real headache.

We need to remember that WIC is complementary to health programs. The health programs funded through the maternal child health block grant and through community health centers provide the critical health services without which WIC would be greatly diminished in its impact. Funding for these programs needs to be supported as well as funding for WIC. We need to expand nutrition education efforts in food assistance programs, such as food stamps, and we need continued emphasis on nutrition education as an integral part of WIC.

I might just speak to the comment about the nutrition education in our school systems. Of course, this is funded largely through the Nutrition, Education, and Training Act. These funds have been substantially cut. Our education department has put some of its own funds into that program, but we really need protection of NET at the Federal level to try and see that we do have good nutrition education in our school system.

We support a 25-percent increase in food stamp allotments as it is very common to hear families who run out of food stamps at the end of the month, and in my personal opinion this is not due to mismanagement solely—this is due to the allotment being inadequate. Some changes in WIC regulations, such as allowing more special formula for infants, would allow us to better meet special needs.

Elderly feeding programs need increased funding to meet the needs of our senior citizens. To ensure that the dollars are spent wisely, professional dietetic consultation at the State level should be required for these Council on Aging programs. We support nutrition education training. We feel that this training should again be included in the National Health Service Corps and that service in rural health department clinics should be an option for payback of support.

As Dr. Rausa said, WIC has allowed us to establish nutrition positions, but it has been very difficult to fill these positions in some rural areas such as in this district. And having nutritionists again available through the National Health Service Corps would help us meet that need.

Finally, we need appropriate and timely data regarding the nutritional status of our population, and in my opinion we do not have that. H.R. 4684, the National Nutrition Monitoring and Related Research Program would help provide for such data.

The Association of State and Territorial Public Health Nutrition Directors, in which I represent Mississippi, has this past week presented testimony in support of this legislation, with some recommendations for minor changes which would strengthen the act. I have attached a draft copy of our testimony.

The fact that the nutrition monitoring portions of H.R. 5151 have been dropped make the passage of this previous act even more vital. It is time to implement such a system, so that we can more accurately know the level of nutritional problems which exist in our population and what impact food assistance programs have.

I appreciate the opportunity to testify before this august group. I hope there will be specific outcomes which you may help bring about, so that in 1985 there will be no need for a hearing of this sort.

Thank you.

[The prepared statement of Ms. Hinton appears at the conclusion of the hearing, see p. 107.]

Mr. PANETTA. Thank you, Ms. Hinton. We appreciate your testimony.

Again, I am going to ask members of the panel to keep their questions as short as possible so we can get to the last panel.

Let me ask, if I can, Dr. Robbins, I understand the statistics that you point to as being specifically related to malnutrition, and yet one wonders with the statistics in Leflore County, I think 1 out of 8 low weight births evidently take place, and I guess the infant mortality rate, some 31 out of 1,000, is among the highest in the State, if not the Nation.

What do you attribute that high infant mortality rate to?

Mr. ROBBINS. You are—let me back away from this a little bit, in that you are asking me questions that are—you know, I am a urologist.

Mr. PANETTA. Right.

I guess what I am asking is, is it possible that that high infant mortality rate, some of that would be nutrition related?

Mr. ROBBINS. Yes, it is possible. And I do not at all say that it is not possible. And let me kind of back away from what Dr. Shirley understood me to say.

Let me underline, I am not saying that we do not have hungry people in the county. I am not saying that we do not have malnutrition in the county. I am saying that we do not have the severe malnutrition that we had that caused these severe diseases that we used to see. Marasmus is a total calorie lack. Kwashiorkor is a terrible sounding thing which is the children with the swollen bellies and all. They used to see that in Leflore County, and we see those diseases not at all. I don't know whether you see them at all, but the doctors that are seeing patients say that they do not see those people.

Now, the other less severe things that were alluded to may well be here, but there is no data at all that—no hard data—that allows us to talk about it. The data is—I mean, the patients are there and they are available to be looked at, but—and it would not be real hard to get it. It would take about a year, but we do not have it now.

Now, as to what you said about low-birth weights and infant mortality rates, I am told by one of our pediatricians that she thinks that the biggest problem with that is—can be related directly toward the very young mothers. When you have 13- and 14-year-old mothers, the children that result from those pregnancies are not nearly as healthy. In fact, we have—I am told that our pediatric intensive care unit in Jackson has the best track record of anyplace in taking care of these little, teeny, tiny premature babies. They get better results than anybody else because they see so many of them and they are related—those very small babies and premature babies who are at great risk of dying, those problems are blamed by the people in Jackson more on the very young age of the mothers than on the other problems.

Mr. PANETTA. I thank you for your response, Dr. Robbins. I would be interested if the hospital would look at the relationship of some of these other areas and I know you are working off the stats that you have, but I think it would be helpful to us, particularly in an area like this, to be able to look at some of these other areas and determine whether they are nutrition related or not.

Mr. ROBBINS. I think that other data would not come from the hospital because these things are not so severe—these things that Dr. Shirley has spoken of—they are not so severe that the patient would be hospitalized. The data would have to come from pediatricians' offices.

Mr. PANETTA. Thank you.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

Dr. Rausa, I was impressed with your statement because of the inadequate certainly by a great opportunity for me to visit some of the very poor people in this county and having discussed with them on a very short basis what they thought some of their problems were. Time after time I heard that the WIC Program was the one program that assisted them in raising their children and I was impressed with your statement regarding the balance of the nutritional food that could be available in the WIC Program and I wondered if you would expand on that just a moment and also give us your thoughts on how we could accommodate that additional nutrition that is necessary in your mind for the WIC Program?

Mr. RAUSA. First, when we—we have a lot of these programs as you all are aware of. We gave our powdered milk and we did not see much response. We now give fresh milk and fresh eggs. The problem that we come up with is that if you give them the 9 gallons of milk for the month where do you store it and so we backed off and got a lot of complaints. Somehow they managed to store it and when we backed off and gave them part fresh milk and part powdered milk, but they wanted the fresh milk. Now of all our counties, this is the only county that has fresh milk and fresh eggs available and I operate nine counties, I am the administrator for nine counties. So there it is not so much a cultural kind of activity that I was talking about in the School Lunch Program as much as having the fresh product that they are used to and take willingly and not having the powdered milk.

The State is considering going to sterilized milk which has never been marketed in this State to my knowledge. I am familiar with it having been to Europe where it is used extensively, but I doubt seriously that it will be incorporated into their daily use even though storagewise it is going to be a big bonanza for these people.

So sometimes what seems to be more efficient and effective for us—the dolers out of the food—becomes ineffective and not so helpful to the recipient and I would like to see some market research done. If they can smell right and look the right consistency you will run and buy it and I think we could do the same thing with WIC in packaging our programs with something so around the country you could talk in different groups, all having a baseline need for additional food but presenting that food in a way that they are used to using it and that it will be maximized into their lifestyle.

Mr. SMITH. All right, thank you.

I have just one question, Mr. Chairman.

Dr. Shirley, I was with Dr. Berkin this morning, a pediatrician whom I am sure you know, all morning and we were—and I, along with her, were looking specifically for malnourished small children. Obviously that takes—that sometimes does not—is not visible. I understand that, but we looked for symptoms and frankly, we did not see any. Maybe we were in the wrong place. The point is that you mentioned—and I know there are malnourished children—we had the indication from Dr. Robbins that the hospital does not see them. How do you identify these malnourished children for us and how many of them are there?

Mr. SHIRLEY. In my county of Hinds County, 25 percent of the children under 5 that we see who are not participating in a Head Start or day care facility, who are not on the WIC Program, 25 percent of those children are anemic by hematocrit determination. That is a fairly clear indication that there is something wrong. Now only 4 or 5 percent of those children that we see who are under 5 are in the WIC Program, attend Head Start or are in a day care facility. The only difference that we can determine is in Head Start and day care and WIC there is a food supplement, whereas those children who are not in those programs are not receiving that and a higher percentage of those children——

Mr. SMITH. Well, certainly that is an indictment of the system and certainly a great commendation for the three programs.

Mr. SHIRLEY. But the anemia factor is one way in which we determine that 25 percent of the children that we see who do not get that are undernourished. Now, in the hospital it would be good if someone would look at those individuals who are hospitalized for surgery, who had to be transfused before the surgery could be performed, and this would be a fairly easy thing to do. Those individuals, elderly people, children, who were in for an appendectomy or tonsillectomy or some elective surgery, the number of those children who had to be transfused because they were not hematocritally at an optimum level, that is an indication of something wrong nutritionally.

And then last, if we look at the death statistics in our State and look at children who died twice as fast as other children, we look at children in poverty who have a much greater morbidity in terms of they are more frequently hospitalized with infection and other problems and those are related to what I mentioned in my testimony, the fact that chronic malnourished children—you look at them in an occasional glance, you say they are not small, they are not boney, they do not have extended bellies, but over year after year after year of hematocrit of 30 percent, 31 percent, these children's body defenses are compromised. So they have to go to the hospital more frequently because the infections are more severe.

Mr. SMITH. Thank you.

Mr. PANETTA. Thank you.

Mr. Franklin.

Mr. FRANKLIN. Would you like for me to yield to the gentleman from Washington for a question?

Thank you, Mr. Chairman.

I have one question. I know we are on a tight time schedule, but I would like to ask this of Ms. Hinton. My staff in the last couple of months has been conducting a pretty extensive investigation into this problem in preparation for this hearing and in the home delivered meals program for the elderly that you mentioned that we have a waiting list there, and in Leflore County I think that waiting list currently is about 21 people.

Who is it that makes the determination as to who gets served the home delivered meals and who does not on that waiting list? Is it a first-come, first-served basis or is there any sort of means test on that program?

Ms. HINTON. I have to admit to ignorance on that, Mr. Franklin. That is administered by the Council on Aging out of the Governor's office. I think Mr. Raff could answer that question for you though.

Mr. FRANKLIN. I believe that that is not a means tested program. The point that I am trying to make is it might be that if we have limited funds available that those funds, in my opinion, should be directed to those that are most needy and I would like to see these programs administered so that those very low end people in greatest need could be served as opposed to the first come, first served on these programs. I make that comment.

Ms. HINTON. I might respond just very quickly to that to say that if we look at the State's statistics as a whole, I think Mr. Raff said that only 3 percent of the elderly in this State are being served through the elderly feeding program while almost 30 percent are in poverty. So I think we can see a tremendous gap between what we have and what we need.

Mr. PANETTA. Thank you.

Mr. Morrison.

Mr. MORRISON. I have been a Member of the Congress now for about 3½ years and during that time the cost of the Food Stamp Program has gone up approximately 50 percent. Now we have heard the cuts and so forth, but from where we sit, the cost has gone up 50 percent in the last 3 years approximately and I would just like to put a question—I am not sure specifically who to put this to, but I know you would love to have the flexibility of the Food Stamp Program and a couple of you—Ms. Hinton, you have mentioned a 25-percent increase. I know Dr. Shirley has mentioned that in the past and perhaps we cannot do that.

We have surplus commodities. The President has made available an expanded program. Webb Franklin tells me you do have a new distribution schedule here. I think it would help. Is the potential answer in the use of surplus commodities that before people go hungry that they would utilize some of these things which are not as convenient and perhaps are not as much fun to eat but they are there and they are nutritious and we already have an investment in them as taxpayers? Would that fit anywhere?

Mr. SHIRLEY. Let me just say one thing about the Food Stamp Program and the Commodity Distribution Program. You can dump tons and tons and tons of surplus stuff here, but if the people who administer the program—if you have got to stand in line in 95 degree heat for 5 or 6 hours, the program does not appear to be designed to help people. It is more designed to get rid of surplus commodities.

If the attitude, the purpose of its presence could be changed as one of relieving hunger rather than getting rid of surplus, then it would go a long way to make the system more acceptable to the people.

Mr. MORRISON. Yes; I can respect that very highly, Doctor. Expand on that a little. How could you do that, more locations, more regularly, better attitude? So far, it has been done primarily through volunteers and I notice the State of Mississippi does not charge for that particular distribution activity. Any other idea on how we could make it better?

Mr. PANETTA. Doctor, if you could just keep your response brief.

Mr. SHIRLEY. OK. In the State of Mississippi, we have an excellent Head Start Program. There are Head Start Programs starting in the neighborhoods where people are—where poor people are. Let the Head Start Programs administer some of these programs, let them issue food. They know who the hungry people are. Let Dr. Rausa and some of his health clinics issue the food or food stamps, make it simple.

Mr. MORRISON. Thank you.

Thank you, Mr. Chairman.

Mr. PANETTA. Does anyone else have crucial questions that need to be asked? I am trying to get to the last panel.

Chairman Leland.

The CHAIRMAN. Dr. Robbins, I would like to ask a couple of questions. Does your hospital have a policy of serving all indigent patients who come in for medical treatment, whether or not they are medicaid eligible?

Mr. ROBBINS. The hospital admits and takes care of anybody that the attending physician orders to be admitted without regard to any payment or ability to pay or whatever.

The CHAIRMAN. Very good. Let me go back to a question that was asked by Chairman Panetta. I, too, am concerned about what infant mortality represents; it is a definite indicator of poverty and, therefore, hunger. Low birth weight can also be a very strong indicator of inadequate nutrition.

One of the statistics that I have seen here in Leflore County that is rather startling and rather unique from what I have heard before—I serve on the Subcommittee on Health and Environment in the Congress—is that the infant mortality rate amongst whites here in Leflore County happens to be 19, 19 per 1,000, as opposed to the infant mortality rate of blacks which is 31 per 1,000. Nineteen per 1,000 is close to double the infant mortality amongst whites in other parts of the country.

Can you explain that?

Mr. ROBBINS. No.

The CHAIRMAN. I am sorry, you are a urologist.

Mr. ROBBINS. I am sorry, I really cannot. Again, of course, you have to understand that all of these things are related to the level of education, they are related to general economic well-being and poverty and ignorance are not the exclusive domain of the blacks in Leflore County by any means, and it is—the general level of education in the white community is less than the national average and so the blacks do not exclusively have that——

The CHAIRMAN. Well, let me just say that we need some data on what is going on here in Leflore County. If these startling statistics are true, then there is definitely a need to get some response from the folks here, particularly representatives of the hospital. We need this information as soon as possible.

What I would like to do then is to ask the midwife, Ms. Moore, if you can respond to the question about the problems resulting in high infant mortality rates.

Ms. MOORE. I have more current information. We have a 5-year infant mortality rate which gives you a little bit of perspective. We try to take it yearly with—it is small numbers. We take one of two infants which, you know, is personal and is an infant but it does make a big impact when you have a small county you are dealing with.

For 1978 to 1982, which is the last data that we have current, the overall infant mortality rate was 25.9. That is 25.9 per 1,000 live births. The white rate was 16.3 and the nonwhite rate was 29.9, so we are dealing with almost twice the white to the nonwhite average.

We also have in Leflore County a 28-percent teenage pregnancy rate which ranks up in the highest in the State and in our district we have the dubious distinction in these nine counties of having the highest infant mortality rate, plus teenage pregnancy rate of anywhere in the State. And of course you know how our State ranks in the Nation. Leflore County is not the worst in the district, however, believe it or not, there are other counties which are worse.

We have seen WIC make a big impact in our health services. We think it has made a big impact. I have to pat the private community here on the back. I know of no other place in the whole State that the private community works as well with the public sector as they do here. We provide basically through the health department, prenatal care for anybody. We are serving 185 percent of our target population, so we are serving those that are poor and those that are not so poor, those that, you know, could make it but it would really put a hardship on the family that maybe are not getting some of the other supplements that the poor get, but still have a hard time. So we are serving 185 percent of our target population for maternity.

As far as infants go, we are serving over 300 percent of our infant population. That includes immunization, WIC services, general pediatric screen and even when the clients do not have money, we refer them out to the private community and the private community takes care of these folks. They see them in their offices, they will admit them in the hospital on an emergency basis. They may not admit them as freely as they do people that have medicaid and private insurance, but in an emergency, they will, and in those cases they refer them back to us.

The patient does not have to bear the burden of repeated private medical expense. They can come back into the public sector and get the baby weighed, get the baby immunized, get the baby on WIC and they refer to us, they have got this baby, I know they cannot feed this child, get it on WIC, you know, do what you can, go out there and weigh it. We will go to the home and weigh these kids and see to them so to speak, because they do not have the facilities and the nursing staff that we do have, so——

The CHAIRMAN. Thank you.

Thank you, Mr. Chairman.

Mr. PANETTA. Thank you.

Billy do you have a——

Mr. MORRISON. No, Mr. Chairman.

Mr. PANETTA. OK. If you will, the other members may submit questions to you on other aspects and we would ask you to respond to those in writing if you could.

Thank you all very much for your cooperation.

The last panel relates to service providers. They are Darlena Allen, nutrition coordinator for the North Mississippi Planning and Development Operation here; Margaret Kibbie, who is with the North Mississippi Rural Legal Services with that operation; Joie Kammer, who is a social worker with Saint Francis Center; and Carol Griggs, who is a social worker with the Delta Health Center. All of them, or at least two, three, or four will be accompanied by some of the local recipients.

If you will take a seat at the table. They do not have your signs up yet. Ms. Kibbie is at the end, Kammer is right here, Darlena Allen. If you would proceed with your testimony. First of all, we thank you—we visited your center—it was an exciting place to visit. I think everybody enjoyed the meal there and we appreciate what you are doing for the community and appreciate your being here to testify for the committee. You may proceed with your testimony.

STATEMENT OF DARLENA ALLEN, NUTRITION COORDINATOR, NORTH MISSISSIPPI PLANNING DEVELOPMENT

Ms. ALLEN. To the committee, I am here as a service provider, services for the senior citizens. The North Central Planning Development District Area Agency on Aging was organized in 1973 to advocate, plan and coordinate programs, especially to serve the needs of 27,000 plus senior citizens living in Montgomery, Leflore, Carroll, Grenada, Attala, Holmes, and Yalobusha Counties.

Services for the senior citizens are made possible through the support of the State and local governments and the district and primarily from title III and title XX funds awarded to the North Central Planning and Development District by the Mississippi Council on Aging.

Services being funded for 1984 include the following:

Congregate Meal Program provides a well balanced meal for over 800 people daily throughout the 17 nutrition sites located in the district. Nutrition sites offer an opportunity for senior citizens to visit with their friends, meet new friends, and learn from the educational programs presented on subjects ranging from preventive health and safety practices to arts and crafts. Also, these sites serve as centers for supporting services, such as outreach, transportation, personal escort, information and referral, legal services, health and welfare counseling, nutrition education, shopping assistance, and recreation.

Locations of these sites for the district are: Kosciusko in Attala County; Carrollton and Vaiden in Carroll County; Grenada in Grenada County; Durant, Goodman, Lexington, and Tschula in Holmes County; Greenwood Center, Threadgill School, Itta Bena, and Sidon in Leflore County; Winona and Kilmichael in Montgomery County; Coffeeville, Oakland, and Water Valley in Yalobusha County.

Home delivered meals are furnished to over 400 home-bound elderly who have documented their need for the services with a doctor's statement. The need for additional services are indicated by the very increasing waiting lists. This service provides a valuable supportive service to frail elderly wanting to remain in their own home. Demands for home delivered meals and in-home services are great and becoming greater.

Transportation services are provided by various supporting agencies equipped with 12 to 15 passenger buses. The district's 22 vans serve more unduplicated elderly than any other service. They take senior citizens to nutrition sites, senior centers, doctors, doctor's appointments, and other destinations.

In-home services are available to older persons who are physically frail and unable to attend to home and personal chores for themselves. These are persons needing some support in order to live independently in their own home. Part time home companion workers provide personal care services and home management duties. The purpose for this program is to provide supported needs to allow elderly persons to remain in their own home as long as possible. Demands for this program are increasing.

Information and referral, better known as Info 60 Plus, is a telephone service that directs elderly persons with special needs to service agencies that can provide health services. Info 60 Plus has information on services ranging from low-income houses for the elderly to legal counseling.

Title V programs.

The Service Comm—the Senior Community Service Employment Program provides employment for persons 55 years of age and older in part-time community service jobs. The major objectives of this program are to help older persons: One, to earn additional income; two, regain their sense of involvement in their community; three, to receive training to improve their employment prospects.

The program is designed to provide communities with competent workers to be used in public or private nonprofit agencies. The project actively works with employers seeking permanent full or part-time employees.

These activities allow older persons to feel—to find employment, thus enables them to contribute rather than be dependent members of society.

Americans are living longer than ever before. Today common record numbers show men and women are living well into their seventies, eighties, and nineties.

Thank you.

Mr. PANETTA. OK, thank you very much for your testimony.

RESPONSE TO QUESTION FOR DARLENA ALLEN

QUESTION SUBMITTED BY HON. WEBB FRANKLIN

Question. Many individuals have mentioned transportation as one of the barriers facing people desiring food assistance. Are there any government agencies providing transportation in this county? If so, are they working adequately?

Answer. In Leflore County we have six 16-B-2 vans. The sponsoring agency is North Mississippi Council on Aging, Dr. Alfio Rausa, director. Under section 18 buses in Leflore County the sponsoring agency is Mississippi Valley State, John Johnson, director.

The transportation in Leflore County is adequate but limited as to its needs.

Mr. PANETTA. Margaret Kibbie, who is with the North Mississippi Rural Legal Services.

STATEMENT OF MARGARET KIBBIE, PARALEGAL, NORTH MISSISSIPPI RURAL LEGAL SERVICES

Ms. KIBBIE. The question that would be asked today is——

Mr. PANETTA. Just a minute, Ms. Kibbie.

Ms. KIBBIE [continuing]. If we are spending so much money on food programs, why are people still hungry? My answer has to be that these programs are too complicated for people to get the benefit from them.

I am a paralegal with the North Mississippi Rural Legal Services and have been there for the last 14 years. Like most benefit programs, we were severely cut in the last few years and yet, we have way more clients to serve than we have to serve, with people getting cut off disability and people having a hard time on food stamps.

As a paralegal, I see people who do not require a licensed attorney to deal with their problems and I represent people before administrative agencies and mainly in disability hearings. In the past, the food stamps—the majority of the complaints we used to have used to be when people had to pay for their stamps, they had to pay too much. Then in 1978 and 1979, when the purchase requirement was eliminated, we did not see any food stamp clients any more. Now and then we would have a food stamp over-issuance case and once in a while somebody would think they had to have more food stamps, but we hardly ever got any food stamp cases. I would say maybe five people in 2 years. And then 1980, we got deluged and swamped with food stamp problems because people just cannot get certified any more.

Now, I looked at the roster of the cases that we had for this year and of 468 active, open cases opened in this year, 43 were pure food stamp cases. That is the people that walked in and said I cannot get certified for food stamps. This does not reflect the people who are in our office for other problems and who also were having trouble with their food stamps, such as people getting unemployment and people who have lost their jobs or people who are having trouble with their disability and are also having trouble with food stamps.

Of these 43 cases, only five of them were fraud cases and we would see a larger portion of the fraud cases because people with fraud will come to the legal office for help. For certification, we see a very small portion of those people because people do not know that we are there to help people with certification problems and they would only come because they have been served by us before or because somebody said go to legal services if you cannot get your food stamps.

Additionally, there have been very bad cuts in other programs and some of the problems in the Food Stamp Program have made more and more problems for our clients. Some of the recent changes in the Food Stamp Program have increased, you know, terrible burdens on our clients.

For instance, the monthly reporting. This has caused a lot of difficulty among our clients and they have had a lot of trouble sometimes 2 and 3 and 4 months to get certified because they cannot get their form filled out correctly or they left out a check stub from 2 months ago. The record keeping in the records that you have to maintain can really become burdensome and complicated for our clients.

The people I thought would really be helped by monthly reporting have not been helped at all and in fact some of them are not even getting food stamps. For instance, a person who is a construction worker or a person who is paid by the hour and does not work the same number of hours every week, I thought that this person would come out better because then they would not have to worry about reporting every change, they would just put it in their monthly reporting form. And in fact, I found out that the families I thought were going to do better are not even getting their stamps because they cannot get their monthly reporting form filled out correctly or because they lost one of their check stubs and they have to get it in before they can get certified.

I will give an example of a family that I have been working with where we had to have an administrative fraud hearing, which they lost because they were overissued $49 worth of stamps because they forgot to report that he worked overtime one week and got a little bit of extra income. And in addition, his family was going through the difficulty of his wages were being garnisheed because his 16-year-old daughter was cut off ADC and medicaid. Her children could get medicaid and ADC but she can't, and so his check was being garnisheed to pay for a C-section that she had to have in the hospital where in the past, medicaid would have paid for that. We have a lot of people that are caught between the cracks on all the different programs.

Retrospective budgeting is another disaster for the Food Stamp Program. There are no exceptions or no way we can get around retrospective budgeting. I have an example of a lady who I represented in a disability hearing who was on the Food Stamp Program and on SSI and Social Security and because of retrospective budgeting, the month that she got cut off disability her son, who was getting $10 worth of food stamps because that is what they got in income the month before and that is the way they had to be budgeted. So for 1 month they have $103 to pay a gas bill, light bill, a $200 house note and buy their food and they cannot catch up with them until the next month when their retrospective budget month takes effect and all the benefits can adjust.

We also have a lot of problems as far as people getting cut off disability, very sick people who cannot be qualified for the food stamps and are not getting the benefits. When I say very sick people, I mean people who have cancer that have gotten worse and yet they are still getting cut off their disability checks and people who have cancer who cannot even get a disability.

We have a lot of problems here with the record keeping that is required for food stamps and food stamp certification. It is exhaustive, it is more record keeping than you would say, have to justify on schedule A on your income tax and you have to have these records with you every time you go out to be certified and recertified.

For instance, when you are going to apply you have got to have eight consecutive check stubs to document your income if you are going to effect an initial application. You also have to have two ID's or verifications of residence for everybody in your household and you have to have these when you go to be certified.

Then too, as you have been told, there are no computers at the food stamp office. I am not so sure I want to see them go on the computer because when they went on computer in the welfare department, people were 7 months before they got a check, but they put it on the computer. Well, here they are, everything has to be done by hand and in the past you could document your income with an award letter or a notice showing what your SSI was, or what your Social Security or what your unemployment was. Now you cannot do that. You have to come out and sign a release of information and this has to go back to the food stamp office—I mean the Social Security office or the unemployment office and they in turn have to return it to the food stamp office before your case can be acted on.

Also, there is no presumptions for truth. For instance, when a person reports an income of $314 SSI, this is how much an SSI check is and it is presumed there is no other income when you report that you have $314 SSI, yet you still have to wait for the Society Security office to in fact verify that you do have this $314 SSI check and also it is the same with SSI and Social Security where you will get $324 if you are drawing both programs, but this still has to be verified.

Mr. PANETTA. Ms. Kibbie, could I ask you to get it wrapped up as soon as you can because we are getting down to the wire?

VOICE FROM AUDIENCE. She can go on in place she is doing such a marvelous job.

Mr. PANETTA. She is. If you would like——

VOICE FROM AUDIENCE. I mean I would hate to cut her short.

Mr. PANETTA. Yes, all right, go ahead.

Ms. KIBBIE. Well, I am going to wind it up anyway. At present, there are not really any good solutions to some of the problems that we are having with food stamp certification. The food stamps—they have a 30-day requirement where they are supposed to complete a case and they are regularly taking over 30 days and I do not think it is necessarily their fault and I have stopped calling the director in the State office on this.

Before 1980, it only took about 2 weeks for people to get certified and then changes are being made in the Food Stamp Program with no particular benefits, just arbitrarily, and the people are not necessarily being helped by the changes and the fair hearings process is not much help either, because fair hearings take too long to schedule and too long to get a solution.

An example is that we have a case where a person wanted a hearing 2 months ago to show that they were supposed to get stamps in March and February and they have not gotten those months stamps yet, and this is June.

Then we have another problem that we see a lot of in legal services with people having to report to the unemployment office or else the whole house gets cut off food stamps and these reports will be kind of arbitrary and not necessarily on point. It is not like you are reporting to an interview for a job, you just have to come to the unemployment office and if you do not come, your whole household gets cut off, and the head of the household is not necessarily notified when they know anything, nobody is getting any stamps.

Then you have to kick out that person who did not report to the unemployment office and in effect get all of your verifications that you are living someplace else. [Applause.]

And in closing, I would just like to say that we would like to see the Food Stamp Program rewritten or reprogrammed or redrafted to benefit the people who need to get food stamps instead to prevent and eliminate waste.

Mr. PANETTA. Thank you very much, Ms. Kibbie. [Applause.]

Let me ask Joie Kammer if you have something?

STATEMENT OF JOIE KAMMER, SOCIAL WORKER, ST. FRANCIS CENTER

Ms. KAMMER. I would like to say that thank you's should be given to people this evening for this program. I would like to thank the Congressmen, but I would also like to thank the physicians who came because I think we, the Congressmen and I, although I work among hungry people and poor, cannot tell the signs of malnutrition. I think the Congressmen and I can see hunger but not malnutrition, therefore, we should not take lightly the report of nine prestigious physicians who have given the facts that there is hunger and malnutrition here in Leflore County.

I think also that we cannot take lightly the fact that welfare benefits so low, the lowest in the United States, $60 a month for a mother and child; $96, a month for a mother and two children, et cetera. Because what we are doing basically here is causing child neglect. We cannot possibly be giving the proper amount of food because the Department of Agriculture says that in order to have a fully nutritious diet you have to supplement the food stamps with the purchase of food. This is impossible with $60 a month welfare benefits. It is impossible to pay gas, lights, and rent and also buy food on $60 per month.

So we must realize that we are automatically causing child neglect and in many cases child abuse because parents become frustrated. It is very important that we get this straightened out.

The redtape of getting food stamps has been so beautifully reported by Ms. Kibbie. But I will say that when people are waiting 30 days for their food stamps which is generally the case, and with the new retroactive program they sometimes wait 2 and 3 months for their food stamps, this is hunger and we have to eliminate these problems.

At St. Francis Center, we know the people are hungry because they come to us asking for food. What we give is inadequate for satisfying hunger. It is an emergency type of thing. In 1983 we gave food 625 times to families and 2,139 times to individuals. These have come to us for food but it indicates that there are many others who also need food. We need to look into the hunger problem. It is a very desperate situation.

Next, there is a lack of jobs. I will tell you, I went through the Allied Enterprise Program where they train people for jobs. I saw this young lady who was pointed out, "look at this young lady, how quickly she makes these artificial fish bait, look at the speed and dexterity of her fingers." Do you know, this young lady after she finished her training has not secured a job. She has been all over looking for jobs, she wants a job, she went to the trouble of getting trained. There are people here who need jobs. She and her two children live on $96 per month welfare.

I would also like to ask the people in the audience to please hold up your hands if your food stamps run out. [Over half of the audience raised their hands.] Our food stamps do not last. Some people are without food stamps for 2 weeks and with all the complicated forms our food stamp operators are not at fault. The Federal Government has to do something about these forms and also please, if you can find the money for more food stamps so they won't run out, and do not put it on the States. Every time you put it on the States we lose out. We are a poor State. They want to help too, but you can do so much and I think it should be an across-the-Nation program all poor getting the same help not some poor getting more than others.

There are so many programs that have been cut. The elderly, they are getting their medicaid cut over and over and they, you know, have many illnesses and need medical care and medicine. They also have transportation problems, so they go to the corner grocery store where groceries are high. They get credit there when their money and food stamps run out, so it's a vicious circle. Our elderly have problems with their food. They need special food and food stamps are just not enough, usually $10 or $20 or $30 per month.

Now the Head Start Program proves that there is hunger because they give tests and find children are anemic when they come into the program. They find the children eat excessively when they start in the program and are lackadaisical. Toward the end of the year they begin to eat normally and have more energy.

Please do what you can. Listen to the physicians. They came here and I know you are glad that they came to alert you of hunger and malnutrition in Leflore County.

I would like to thank the members of the Head Start Program who worked so diligently with me and the domestic professional aides who coordinated the hearings. We planned the tour and hearing and circulated information to get the people to the hearing. Over 400 persons are present.

We thank the Congressmen and the people for coming.

Mr. PANETTA. Thank you, Ms. Kammer.

OK, Ms. Alexander, would you identify yourself and who you are with and you may proceed.

STATEMENT OF JANICE ALEXANDER, DELTA HEALTH CENTER

Ms. ALEXANDER. Good afternoon. I am Janice Alexander. I am with the Delta Health Center in Mound Bayou located in Bolivar County.

The Delta Health Center opened in the fall of 1967. It came into being through the efforts of Dr. Count Gibson, head of the Department of Preventative Medicine, Tulsa University and Dr. Jack Geiger, professor of the Department of Preventative Medicine, Tulsa University.

The center opened as a sister facility to Columbia Point Comprehensive Health Center, Boston, MA. Doctors Gibson and Geiger were able to receive funding for what we owe for two projects, one rural and the other urban to demonstrate that an ambulatory health facility would function as a health maintenance mechanism as well as a disease prevention mechanism.

Today, Delta Health Center services approximately 23,000 patients per year. The various service departments at the health center include hypertension, medical services, includes podiatry, transportation, nurse midwifery, WIC, nutrition, social services, and pharmacy. Of this number served by the health center, 80 percent of them fall on or below the poverty level. The majority of clients served receive food stamp assistance but have very little or no income coming into the home.

When an emergency occurs, such as illness or the need to buy medication or utility bills, individuals may be forced to illegally sell food stamps to obtain money. Individuals are responsible for bills and other living expenses, even if this only includes their utility bills. The expense checks received by most Mississippians are not enough to carry them over from month to month.

To combat some of the nutritional problems facing patients at Delta Health Center, two departments were incorporated, WIC and nutrition. Eighty percent of the clients served by the Delta Health Center WIC Department have a lack of education as to proper foods and nutrition. Teenage mothers do not know how to prepare formulas and some infants seen suffer from failure to thrive. From talking to our pediatrician, that number is a very small number, maybe four to five cases per year, but the incident does exist. Most patients do not know how to shop for their foods with nutritional values, therefore, the problem of malnourishment is enhanced.

A large number of patients served to Delta Health Center are obstetrical patients. Most OB patients suffer from excessive weight gain or very little weight gain. A big problem with teenage pregnancies is premature deliveries and poor nutrition. The nutrition department provides counseling for diabetics, overweights, underweights, pregnant women, whoever needs help.

Approximately 60 percent of clients in this department have a lack of knowledge as to the preparation of a well-balanced diet. Extensive counseling is done to patients on basic concepts of nutritional value of foods. To help those individual patients who cannot read, audio visual aids are available.

In 1980, an Outreach Program was devised. Its main objective was to contact those individuals in the service area who are not able to come into the center due to certain circumstances such as lack of transportation and provide nutritional counseling to them. Due to a lack of funding, this service was terminated in 1982. As a result of this termination, people in rural areas are unaware of the possible aid available to them or do not have the transportation necessary to seek these services.

We have some suggestions here from the health center that we believe can help achieve maximum effectiveness in the services provided. In many instances times between applying for services and receiving service benefits can be so long that people are forced to do without for some period of time. Very little communication is upheld between the client and the supportive agencies.

Attempts should be made to decrease the amount of time it takes to complete applications and receive benefits. Mississippi should adopt some kind of policy where when a person goes in and a family is hungry and needs some food they can receive aid when they first apply instead of having to wait 2 or 3 months to get some results.

I have with me Ms. Mary Henderson. As a social worker, I am required to do home visits and you would be surprised at some of the houses I have had to go to, houses where you could step in and look up and count the stars and still have to pay rent on these houses.

Still have to pay a light bill and then what surprised me most is some of these people I talked to, my clients, are not eligible for food stamps because they say you have to report some type of income to get food stamps. If you go in—if I did not have a job, was not receiving any unemployment, if I had kids, if I said there was no money coming to my house, too bad, I am just out of luck.

That does not make any sense to me. I have—Ms. Henderson is with me. She is an employee at the Delta Health Center also and she is here on behalf of her mother. Her mother is very ill and was not able to make it over here with us today, but she is an elderly lady and she will explain her situation to you and maybe you all can understand it because we have been trying for the longest to figure it out.

[The prepared statement of Ms. Griggs and Ms. Alexander appears at the conclusion of the hearing, see p. 124.]

Mr. PANETTA. Would you identify yourself for the record, please.

STATEMENT OF MARY HENDERSON, ON BEHALF OF HER MOTHER, LUCILE STEVENSON

Ms. HENDERSON. I am Mary Henderson, the daughter of Ms. Lucile Stevenson. I was unable to bring her today. I was unable to bring her with me today because she is too ill.

In May of this year my mother was cut off her SSI check and they told me they cut her off because I moved her in with me and she was unable to live by herself because she is bed confined and when—and then they told me that after she lived with me for 6 months that she was not supposed to draw her SSI check and before then, she was hospitalized for 3 months and they told me—

Social Security told me that I should report to them that she was in the hospital for 3 months but I did not know that I was supposed to report to them when she was in the hospital and then she had to pay that money back because they said she was overpaid because during the time that she was in the hospital for 3 months she was supposed to report it and she was not supposed to receive a check.

And her living with me I reported to them in June 1983. The same day that I moved my mother in with me, I went into the Social Security office and reported to them that I had moved my mother in with me, but they did not tell me anything about after 6 months of living with me that she would not receive her SSI check. And then they sent me a letter that she owed them 3,000 and some dollars due to the fact that she was living with me for the past 6 months and did not report it, but it was reported and so I still have my mother with me now and she does not have any medicare or medicaid and she does not get an SSI check and she is also bed-confined. She has to have some health nurses and, you know, all this stuff and a whole lot of expenses.

Mr. PANETTA. Excuse me, but have you appealed that case?

Ms. HENDERSON. I appealed it the first of May, but I have not heard anything from it.

Mr. PANETTA. Are there any others that would like to say a few words?

Ms. West.

STATEMENT OF MS. WEST

Ms. WEST. Mr. Panetta, I would just like to speak. My husband has been out of a job for over a year and he is laid off and he applies to the unemployment every Monday and they say they do not have anything for him to do.

I have high blood pressure, slow beat of the heart, sugar diabetes, and bursitis. I do not have any money to pay for my medicine, so I have to let it go because I am not able to get it and I have tried to get on and get SSI. They say that I have to have one of my eyes out or leg off before I receive a little SSI check and so I just thank God if I can see and can walk I would rather just do the best I could.

They give us $46 worth of stamps and it do not even meet our needs. I will be hungry and there Ms. Joie, she has brought food to my home.

My husband mows and he makes $35 and $40 mowing yards and if it were not for that I do not know what I would do and I really needs help and I needs to pay all my medicine. I have been out of my heart medicine almost 3 years and a lady asked me—I wasn't able to buy it—and a lady asked me so what have you done and I says well, I guess I am living off of faith, Jesus takes care of me. That is all I can do and so that is all.

My husband has fluid but he is trying to do the best he can. I am 57 years old, he is 57. He was born on October 25, 1926, and I was born October 5. We were married on October 28, 1944, so thank God, we have been together over 30 years, but I have never been in this kind of condition in my whole life. What hurts so bad, I am out of my insulin now. I took my last shot today. She visits my home. I do not know where any more insulin is coming from and so Ms. Joie came to my home yesterday, she visits me and she brings me a little food every now and then and told me, Ms. West, I want you to appear today and I tried to do what she said.

Mr. PANETTA. Thank you, Ms. West.

Ms. KAMMER. Is Ms. Hampton here? Ms. Hampton is scheduled.

Mr. PANETTA. Just a moment.

Go ahead, Ms. Neal.

STATEMENT OF NORMA NEAL

Ms. NEAL. My name is Norma Neal and I would just like to speak a word of encouragement to senior citizens and I believe that every day and everything to help I help and I just wish all of the senior citizens would come and take a part more than what they are doing, especially my people. I think it is wonderful, it is really grand, it is such a good thing that the Government has put out for us. I just pray you keep it around.

Mr. PANETTA. Thank you.

Mr. HAMPTON. Oh, would you identify yourself, please?

STATEMENT OF OSCAR JULES WALTON, CLEVELAND, MS

Mr. WALTON. I am Oscar Jules Walton and I am from Cleveland, MS and I sit in the category of trying to get disability.

OK, I got hurt in 1981. I lost my job because of the injury. OK. I have five children at home. I cannot get any kind of help from the welfare department. They said I can adopt my kids out they would help me, if they would leave home they would help me.

OK. I am trying to keep my family together. I have not worked since 1981, July 20, 1981. I would like to have a job but the doctors tell me that I have got multiple sclerosis. I have got high blood pressure.

I have contacted the Congressman's office and he said if I get confirmed of my illness that Social Security would—he would send it to Social Security.

That has been done. It has done been made. I have heard nothing from them. My family needs help.

The food stamp office gives me $399 a month. That is what I live on. Now I did get a disability payment in the last 2 months, which has helped, but most of that had to be paid back, you know, for medical things and it took me—I have got no help at all.

Right now I do not have any. I mean I get my help from Mound Bayou and they did—they let me have my medicine and my doctor bills for my family and have went way past the limit to help me, but nobody else in the State of Mississippi—I had to go out of the State of Mississippi to get my help, to find out my diagnosis.

I have got two girls at home that have curvature of the spine and it was found out of State. I have been to the hospital in Jackson. They bill me $248 every month. They did not find anything wrong, but—OK, which I do have, but my situation—I need some help somewhere now.

I need my Social Security now. I paid my Social Security. I worked and I would be at work today. If any of you have a job for me, I will work I need to work, but in my situation now this walking cane is not for looks; it is because I have to have it and I feel like that I earned mine and I expect mine.

I do not think I—this has been 3 years I have been trying to get disability Social Security. I know they have their process to go through, but I am in a category where I want to keep my family together. There is nothing for me.

It was even suggested that I leave the State to go to another welfare State to keep my family together and that was a State agency. You can believe it if you want to. I can show you the people I talked to.

I talked to legal aid. My name is on legal aid thing for the Social Security, but they turned me down on my hearing. It is on the legal aid thing. Sixty days is all you have.

OK. That time is gone and I have not heard from legal aid. I mean I need help today. Not tomorrow. Thank you.

Mr. PANETTA. Thank you very much.

Did you want to say—what I would like to do is let you conclude the statements. There may be some questions here to ask the people that are here. Go ahead and proceed if you have something to say.

STATEMENT OF AUGUSTA COLLINS

Ms. COLLINS. My name is Augusta Collins. I have been sick ever since 1972. I have been trying to get disability and I cannot get it. I have heart disease and I have arthritis; I have high blood pressure. The doctor told me here Monday that I would have to have a brace on my legs and I have been trying—Margaret Kibbie here, she has been trying to help me, but every time I go there I get turned down.

I need help. I get $60 a month for my little grandchild which was given to me from the welfare. My lights are on, my water is cut off. I do not have gas to cook on. I have to cook on the hot plate. I really need help. I have been trying ever since 1972 and every time I get turned down. I do not have water. I have to haul water and when my car does not have gas, I cannot get water, so I really need help.

Mr. PANETTA. Thank you very much. I appreciate your coming and your statements from all of you. It is important that we hear not only from the people that run these programs but by the people that need the help that these programs are supposed to provide.

Thank you for that.

Ms. Kibbie, let me ask you. You have a good rundown of the problems that we are facing. I would appreciate it if you could summarize that for us and send it to me so I can look at the specific problems here.

You are right on—you know, you are hitting exactly the bureaucracy problems that we are running into and I just need to have that information as much as you can give.

[The information referrred to not received by the committee.]

Mr. PANETTA. Let me ask, you had indicated that people, when they do not have any income, have a hard time, and cannot qualify for food stamps. Is it the problem that they have to show that they are not getting any income? Is that the problem——

Ms. KIBBIE. OK. What I am saying——

Mr. PANETTA [continuing]. To qualify for food stamps?

Ms. KIBBIE. To qualify for food stamps you have to report some type of income coming into your household.

Mr. PANETTA. Well, my understanding is, you do not have to show that you have got any kind of income, but——

Ms. KIBBIE. No.

Mr. PANETTA [continuing]. But, if you do not have any income, you have to show you do not have any income?

Ms. KIBBIE. No. If you do not have—OK, you have to show some type—if you go down there and say—from my experience for my clients, if they go down there and say I do not have any income, I am not getting anything, no money, you are not eligible for no food stamps.

Mr. PANETTA. Well, let me say that—they may well be saying that, but the program is supposed, is designed to assist not only those that are on low income, but those that have no income.

If they are saying that, it is basically illegal, frankly, unless what they are saying is we do not believe you are not getting any kind of income and therefore dismiss you on that basis.

That is something else.

Ms. KIBBIE. No. OK. I have had several patients that have gone to the food stamp office, reported no income and I had to come back to my office and I had to help them to get verified statements saying that they had sons and daughters in Chicago or New York or wherever giving them $20 and $30 a month. That was the only way they could get on. When they said no income, they got no food stamps.

Mr. EMERSON. You heard what she said; 25 percent of the people on food stamps have no income.

Mr. PANETTA. Yes. Mr. Emerson points out that 25 percent of the people who receive food stamps have absolutely no income, so if there are those cases, frankly, I would like to hear about it and I am sure the local congressional office ought to hear about it because that is basically violating the terms on which stamps are provided, so I appreciate that information.

Mr. Leland.

The CHAIRMAN. I do not have any more questions. Thank you.

Mr. PANETTA. Mr. Franklin.

Mr. FRANKLIN. No more questions.

Mr. PANETTA. OK. I want to thank all of you again for testifying. We appreciate your coming here and providing your statements.

Let me say as we conclude, because we now have to jump into a car and rush off to Memphis to grab an airplane, let me first of all thank all of the staff and all of the local officials who helped organize the trip and gave us the opportunity to be here in Greenwood and in the surrounding vicinity to look at the problems that are here.

I want to thank all of the witnesses who testified for taking the time to come here and testify and prepare your statements. You have been very helpful.

I want to also thank all of you in the audience who have come here to listen to the testimony and to, I think, participate in the process that we have to go through if we are going to deal with these problems.

Let me assure you that all of us are frustrated by the problems that we face. All of us are frustrated by the solutions because they are not always providing the answers that they should be and so we have a responsibility to try and make those programs work.

We know that despite all of this in a land like ours we ought not to tolerate problems that we see here in this town; we ought not to tolerate hunger anywhere in this country. This is a land that has made a promise to people that everyone will be able to live in dignity. I think that is a promise that we have to insure we live by.

If we can take, as a result of this hearing, one small step in the right direction to try to help people, it is a success. Believe me, your presence, the testimony we have seen, the things that we have seen today have all been worthwhile. For that, we thank you.

Mr. Leland.

The CHAIRMAN. I thank the chairman of the task force for his statement. I can only identify with it and reinforce its sentiment. I, too, want to thank all of you for your participation today.

We have seen some very startling things as we walked through Greenwood and Itta Bena and places that I have heard of but never before had the chance to see firsthand.

We have met some very beautiful people and children in particular. I am very, very sensitive about children and I saw some beautiful children today.

As the chairman said, this is America and this is a place for opportunity and for the pursuit of happiness which is guaranteed to all. I hope that indeed this committee can go a step forward in doing something to help.

We do not want to promise you that we can to do a whole lot. Believe me, our presence does not mean that we want to raise expectations that a lot of things are going to change overnight, in 1 week or 1 year. But I can promise you that—as indicated by this congressional hearing and by the presence of several Members of the U.S. Congress—we do care.

It means a whole lot that Members of Congress from across the country would travel to this place to try to make you understand that we do care, but at the same time we want to make the Congress understand that there is a problem here.

So we are here to do as much as we can to identify as many of the problems as we can, but it is going to take a long time. The problems did not develop overnight, the solutions will not be here overnight.

So, working together, however, you with your Government, I think that we are going to be able to make great strides not only for this community but for this country.

You might be unique in terms of some statistics, but we have seen some of the problems that you have told us about all over this country and you are representative of what those problems are that we have to solve. We are up against a number of complex problems and we are going to take on those problems.

Thank you very much, Mr. Chairman.

Mr. PANETTA. Mr. Franklin.

Mr. FRANKLIN. Thank you very much, Mr. Chairman.

Ladies and gentlemen, I do want to thank everyone who came and participated in this program and I also want to thank the fine staff assistants in my office and those of the other congressional offices, and particularly this task force, for being able to work up this hearing where I do think we will accomplish something from the information that we have received.

Basically we have been talking about this problem in a very general nature. I am the Congressman who represents this area. I am responsible in helping you with specific programs some of you have just mentioned who testified right at the end.

I have a staff. My office is located in the Federal Building, which is the post office here in Greenwood.

I want to be responsive to your needs and I consider it part of my job to help you with your individual problems through the network and redtape of the Federal Government and kind of be your liaison with your problems in the Federal Government.

Please, if you do not believe in me politically, then at least accept the fact that my responsibility is to help you through these mazes of networks and if you will call on us for our assistance, I will assure you that we will put forth our best effort in trying to see that your needs are met through the various Federal programs that we have heard testimony about today.

Thank you, Mr. Chairman, for letting me be a part of this program and inviting me to sit with this panel.

Mr. PANETTA. Thank you. Thank you again. This hearing is now adjourned.

[Whereupon, at 4:12 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Good afternoon: I am pleased to be here today and eager to participate in this first field hearing of the Select Committee on Hunger.

At the outset, I would like to extend my thanks and the thanks of the committee to our hardworking colleague Webb Franklin. His gracious invitation helped to confirm the committee to come to Greenwood to conduct this important proceeding. His staff has provided invaluable assistance to individual members and the committee's staff as we prepared for this first formal hearing. Mr. Franklin's cooperation has been complete and should be recognized as such.

I have come here to learn and I have seen firsthand the poverty and the hunger that exist here. It is obvious that, somehow, all of the programs provided by the Federal Government are not completely accomplishing what was originally hoped for when the programs were established.

Looking at the national statistics, we see a general uptrend in both the level of funding and participation in key nutrition assistance programs.

In the food for women and children program participation has increased five-fold between fiscal years 1975 and 1983, to over 2.5 (M) million. Funding has risen from 89 (M) million dollars to over one (B) billion dollars during that same period.

Assistance for senior citizens under the Older Americans Nutrition program has more than doubled, from 125 (M) million dollars in 1975 to over 381 (M) dollars in 1983. Participation is up by almost 100 percent over that period, with almost 3.8 (M) million people being touched by the program.

Funding for food stamps has risen from 4.3 (B) billion dollars in fiscal year 1975 to over 11 (B) billion dollars last year. About 1.8 (M) million more citizen were enrolled last year than were in 1975.

Looking at aid to families with dependent children, expenditures have risen from 4.5 (B) billion to 7.3 (B) billion.

Futhermore, the dollars spent for the National School Lunch Program have increased from 1.2 (B) billion dollars nine years ago to over 2.3 (B) billion dollars last year.

The statistics point to a general upward trend in food assistance.

Senator George McGovern of South Dakota acknowledged this in the Senate Subcommittee on Nutrition Report in 1979—Hunger in America: Ten Years Later. He said, "Poverty is still a fact of life, but in the area of food, there is a difference, according to the field foundation medical team. Today's nutrition programs reach more people with more direct aid than any other program except social security.

Senator Bob Dole of Kansas, in that same report also acknowledged an alleviation of hunger, saying "congressionally mandated food assistance programs appear to have brought this improvement."

There is still work to be done. That's why this committee was established. There are basic questions crying out for answers.

Are there programs that are not reaching those who are eligible? Are there laws or regulations hindering implementation of these aid programs? Have we overlooked the unique needs of rural areas, such as Leflore County, when we craft assistance programs? Are there underlying socio-economic trends that undermine progress?

To answer those basic questions, we need to gather hard data here so that we can evaluate the situation. On the basis of that evaluation we can propose constructive steps. Hunger and poverty are endemic. How can we break the vicious cycle?

Once again, I would like to thank our colleague Webb Franklin for all he has done to assist the select committee in coming here so that we might take a thorough look at the situation.

Mr. Chairman, I look forward to a productive and informative hearing, and I thank the witnesses for giving us their time today.

Prepared Statement of Hon. Leon E. Panetta, a Representative in Congress From the State of California, and Chairman, Domestic Task Force on Hunger

I am Representative Leon Panetta from California. I currently have the privilege of chairing both the Task Force on Domestic Hunger of the Select Committee on Hunger and the Nutrition Subcommittee of the House Agriculture Committee.

Exactly 17 years ago, in June 1967, a team of physicians testified before a Senate subcommittee on what it had found on its recent visits to poor families in the Mississippi Delta. They stated:

"In sum, we saw children who are hungry and who are sick—children for whom hunger is a daily fact of life and sickness, in many forms, an inevitability. We do not want to quibble over words, but 'malnutrition' is not quite what we found; the boys and girls we saw were hungry—weak, in pain, sick: their lives are being shortened: they are, in fact, visibly and predictably losing their health, their energy, their spirits. They are suffering from hunger and disease and directly or indirectly they are dying from them—which is exactly what 'starvation' means."

Today this committee once again examines the nutritional status of the poor in rural Mississippi. I expect we will find that, largely due to the expansion and improvement of Federal food programs, conditions here have improved since 1967. Yet, the initial reports indicate that a significant problem of malnutrition and undernutrition remains.

The committee has come to take a balanced first hand look at conditions here in Leflore County. No doubt, we cannot learn everything there is to know in one day. But we have tried to plan our day so that all relevant facts, conditions, and viewpoints can be presented to us. If we fail to gain a complete and accurate picture of local conditions, we have not done our job. We want to hear the full story.

For those who may not be aware, this hearing is part of an intensive, continuing effort by Congress to examine and address the domestic hunger problem. Over the past sixteen months, Representative Bill Emerson and I and other members of the Nutrition Subcommittee have traveled throughout the country to gather evidence on the extent and causes of hunger. We have been to Cleveland, Birmingham, Los Angeles, Chicago, and Miami. Many additional hearings have been held in Washington.

The testimony we've heard leaves no doubt that there has been a significant increase in the number of Americans who have difficulty feeding themselves from month to month. Witness after credible witness—including big city mayors from both political parties, religious leaders, United Way Representatives, State welfare administrators, business leaders and others—have described a dramatic growth in the demand for emergency food assistance. These findings have been confirmed by reports of the U.S. Conference of Mayors, the General Accounting Office, the Citizens Commission on Hunger in New England, and many others, including the President's Task Force on Food Assistance.

In addition, our subcommittee has heard testimony from doctors, nurses and other health professionals citing a growing body of evidence that links the current hunger problem with significant health problems—such as improper growth rates in children. I suspect that more evidence along these lines may emerge from the hearings the Select Committee on Hunger is conducting this summer.

To respond to the hunger problem, Representative Emerson and I, along with many others, have worked together on two significant pieces of legislation. Last year, we were successful in gaining adoption of legislation to expand and improve the distribution of surplus government commodities. And this year we are seeking pasage of H.R. 5151, a bill that would provide essential benefits, increase work incentives, and improve nutrition education services for our most vulnerable citizens.

Today we hope to find out what else, if anything, needs to be done. In so doing, I think it is particularly important for us to thoroughly explore the status of the social safety net in Mississippi.

A key question is whether the level of ADC payments in this State is contributing to hunger problems. The maximum payment Mississippi provides to a mother with two children is $96 a month. Not only is this the lowest in the Nation, but it equals only one-third of the State's standard of need. With basic public assistance payments so low, intense pressure must be put on a family's food resources. We really need to know how families survive on this income. Are many of them forced to sell their food stamps in order to meet other pressing needs?

Additionally, I am concerned that food stamp dollars may not buy as much food as they should. Federal food stamp benefits today are based upon only 99 percent of the costs of the thrifty food plan, the Department of Agriculture's lowest cost diet. But here in Mississippi, there is also a six percent sales tax on food, the highest in the Nation. This means that even those persons receiving the full food stamp allotment receive only about 93 percent of the costs of the thrifty food plan. If one also considers that many food stamp recipients are forced to shop at smaller stores with higher costs because they lack transportation or because only those stores extend credit to those out of money, it seems likely that many poor households have great difficulty purchasing an adequate diet.

There are many other relevant questions I would pose. Are there children eligible for WIC or Head Start who are not served? Is there a need to expand the school lunch or breakfast programs? Are health and nutrition education services sufficiently available? I hope our witnesses will address these issues, as well as suggest the ways in which the Federal Government can be helpful in meeting basic human needs.

In closing, I would like to thank the people of Leflore County for welcoming us here. I know that many local people have worked very hard to arrange our day here. I am confident that your hard work will pay off. I look forward to an informative and challenging hearing.

PREPARED STATEMENT OF BEVERLY W. HOGAN, EXECUTIVE DIRECTOR, GOVERNOR'S OFFICE OF FEDERAL-STATE PROGRAMS, STATE OF MISSISSIPPI

Ladies and Gentlemen, I am Beverly W. Hogan, Executive Director of the Governor's Office of Federal-State Programs for the State of Mississippi. I want to extend a welcome to each of you from Governor Allain to our state and to share our appreciation for your presence in Mississippi to continue to explore the extent of hunger—a condition that taps the consciences of all caring men and women.

James Baldwin once said, "Everything that is faced cannot be changed, but nothing is changed until it is faced." I believe that statement is most appropriate to place in our minds today as we examine the extent of hunger in this state and in this nation. It would be more comfortable for all of us to not be confronted with a harsh reality such as hunger among our citizens in what is viewed as the most prosperous nation in the world. Because as caring men and women, it saddens us while compelling us to act when we are faced with the fact that even one child in our state goes to bed hungry.

It is significant that the U.S. Congress has formed a House Select Committee on Hunger and that you are in Mississippi today—twenty (20) years following the beginning of the War on Poverty. To the extent that we have made progress, we have not eliminated hunger. In fact, it is safe to say that the number of persons joining the poverty rolls has increased. In addition, because of the policies enacted in the last three (3) years, there are countless Mississippians who are no longer eligible for services formerly provided by these programs. Many people lack employment and income that would enable them to buy sufficient food. This situation has worsened as the economy has declined. Public assistance and spending for social programs have not kept pace with inflation.

Mississippi is a rural state with 53.7 percent of its population living in rural areas. Twenty-four percent of all people in Mississippi live in poverty; the highest percentage of any State in the nation.

According to the 1980 Census, the number of Mississippians at or below the poverty lines has increased. The total population for Mississippi is 2,455,065.

	Number	Percent
Below 100 percent	587,450	23.9
Below 130 percent	803,523	32.9
Below 140 percent	870,679	35.5
Below 150 percent	937,835	38.2

Mississippi has the lowest per capita income of $7,409 as compared to the U.S. average of $10,495.

However, the War on Poverty brought a number of government programs to combat poverty and eliminate hunger to Mississippi. These programs have proved to be efficient and effective in directly addressing hunger in this state. I want to present a brief overview of these programs, thus, allowing the agencies' directors or representative to expound on each program with specific information on how the programs are working.

The State Department of Health operates the WIC program which provides supplemental foods to some 87,000 women, infants and children monthly. This figure represents 57 percent of the potential eligibles. It operates in all 82 counties. The fiscal year 1984 funding level is $31,000,000. The average food package cost was $23.26 per participant in fiscal year 1983, $9.00 less than the average cost of a food package cost in the other Southeast Region States. Due largely to the WIC program, the infant mortality rates are improving in our state. For the expectant mother, adequate nutrition with appropriate protein intake contribute greatly to producing a healthy baby. Adequate nutrition continues to be important throughout the formative years of a child's life.

The Department of Public Welfare operates the Food Stamp Program and Aid to Families with Dependent Children (AFDC). The Food Stamp Program has become the mainstay in food assistance in our state. According to the Department of Public Welfare's data, while 32.9 percent of the population is at the 130 percent poverty level, only 19.11 percent participate in the Food Stamp Program.

In view of the state's economy and income levels, and high unemployment rates, it is easy to surmise that many elderly and disabled citizens living on a fixed income at the 130 percent poverty level are hungry because the necessities of life—medical expenses, high utilities and other services necessary to survive—require a great portion of their fixed income.

The AFDC program privides assistance to needy families with dependent children and aged or the disabled based on the poverty standards for the number in the household and/or disabilities. AFDC program currently serves 633,690 families in the state and 1,337,993 children with total recipients of AFDC benefits totalling 1,845,691. The funding level for the year ending March 31, 1984 was:

Federal	$44,816,686
State	12,936,775
Total	57,753,461

The Department of Education operates the School Programs, Child Care Food Program, Summer Food Services and Food Donation Program. The School Breakfast and Lunch programs are made available for public and nonprivate schools, high schools or grade schools. The School Programs are important and as, state government officials, we must encourage greater participation of our needy citizens. Good nutrition is important in the development of children. A hungry child cannot learn. The average daily participants for the Breakfast program is 118,541 and for the

Lunch program, 370,829. The number of schools on the Breakfast program is 547 and the number on the Lunch program is 940. The total number of children served in the Breakfast program is 19,759,163 and the total number served in the Lunch program is 63,671,749. The funding level is $90,254,380 of which $23,873,084 come from local contributions; $4,100,000 come from the state required match and $65,281,296 come from federal funds. Eighty-three percent (83 percent) of all children on a given day in school participate in the Lunch Program.

The Child Care Food Program is avialable for public and non-profit private day care centers, settlement houses, recreation centers, family and group day care home programs, Head Start centers, and institutions providing day care for handicapped children. The program serves 28,068 on the average daily. The federal funding level is $10,429,516.

The Summer Food Services makes food available to public or private non-profit insitituions for children from areas in which poor economic conditions exist. The average daily participants total 24,405. The federal funding level is $1,448,321.

The Food Donation Program makes food distribution to qualifying households, individuals and children, child feeding programs, schools, charitable institutions, nutrition programs for the elderly and non-profit summer camps for children. The elgible participants are certified by the Welfare Department. Total rcipients—391,929 of which 374,429 are schools and 17,500 are institutions.

The Governor's Office of Federal-State Programs operates the Low Income Home Energy Assistance Program Weatherization Program and the Aging Program. Mr. Michael Raff of the Governor's Office of Human Development, Federal-State Programs is here with me and will follow my presentation to discuss these programs and how they benefit the citizens in our state.

These programs are making significant progress in addressing hunger in our state. The programs offer hope to our children that they will be provided an opportunity to enjoy healthy and productive lieves. But, these programs have not completely eliminated hunger.

Our state has lost a total of $1.0 billion in federal aid since 1981, an amount equal to $397 per person in the state. It ranks first in this country in losses for Child Nutrition, second in losses in Health Services, fthird in lost funding for Educationally Deprived Children and Appalachian Regional Programs, fifth in Community Services losses, eighth in Social Services and Rehabilitation Services losses, and ninth in lost funding in Education.

The losses in payment to individuals totalled $315 million or $123 per person. Mississippi ranked second in per capita income losses in the Food Stamps and Supplemental Security Income Reductions.

I believe it is time to redirect our social philosophy—time to again believe that the federal government should spend money to take care of its people. I believe that federal funds should be used as a tool to guarantee and improve the general welfare of its people. More importantly, I believe that government should be caring. Those of us in government should be challenged by the information and statistics we will hear on hunger in this state. We must continue these programs. We must join in partnership with businesses, private, non-profit social and civic organizations, and churches to create awareness (if that is needed) and to increase our efforts, through these programs, to ensure that not one child goes to bed hungry in our state.

It is the responsibility of government to care for its people, and government can be an advocate of what is truly needed for the development of its people. As government officials on state and national levels, we should be catalysts, initiators, enablers, and facilitators for the needs of our states, our nation, and our people.

The people have placed their trust in our leadership to be responsive and responsible. Let's not close our eyes to what is real in fear that we may be blamed for its existence. Rather, let's face the situation and move to strengthen our programs to address conditions such as hunger and look for innovative ways to form stronger partnerships in our communities, our state and our nation.

Prepared Statement of Michael Raff, Director, Governor's Office of Human Development, and Acting Director, Mississippi Council on Aging, State of Mississippi

I am Michael Raff, Director of the Governor's Office of Human Development. I am also Acting Director of the Mississippi Council on Aging. The social services agencies within the Governor's Office of Federal-State Programs are combined into one major department—The Office of Human Development. This office has administrative authority over the Governor's Commission for Children and Youth, Governor's Office of Energy and Community Services, Governor's Office of Handicapped Services, Governor's Office of Voluntary Citizen Participation and the Mississippi Council on Aging.

Before joining the Governor's staff last January, I spent 14 years as the Director of the Mississippi Council on Human Relations and then as Director of the Mississippi Legal Services Coalition. In these capacities I have been working with communities in need and the programs that are designed to meet those needs. I am familiar with the problems of the poor in this state with the highest poverty rate in the nation and have worked for the enactment and effective implementation of programs to aleviate these problems.

During the last 14 years I have seen significant gains in Mississippi in the fight against poverty and hunger because of a federal commitment to programs that address the specific needs of the poverty population. We attacked hunger with food stamps and it notably reduced debilitating malnutrition among our people. Other nutrition programs supplemented this basic program and where targeted on particularly needy groups such as pregnant women and elderly. Other poverty programs have helped families get their feet on the ground so that they could fight off economic deprivation. Civil rights compliance helped many Black citizens gain an opportunity for education and economic opportunity. Together this array of programs helped reduce the amount of poverty in our state and set a base of decency for those unfortunate enough to remain below the poverty level. The recession and the failure of the federal government to adequately respond to the conditions produced by that recession have caused us to begin a backslide.

We need to once again take the road toward eliminating poverty and its devastating effects on our people. This will take a renewed commitment to programs targeted at the needs of the poor and their communities. We have about one-fourth (¼) of our people mired in poverty—most of them struggling with part-time or off-season employment or pay their ever increasing bills. The increase in utility costs and the inability to find stable work has drained the capacity of thousands of Mississippi families to meet their needs. With the help of federal nutrition programs, people are able to eat most of the time, but not all the time. Food stamps run out before the end of the month and the households are called to make hard decisions. Essential needs, not frills or extras, frequently compete with food. Whether to heat their homes, to fill their drug prescriptions, to pay their rent or to eat are the choices they have.

Today you are in Leflore County which is in worse shape than the state as a whole; 34.9 percent of the population live in poverty; 28 percent live below 75 percent of the poverty level. The situation is particularly critical for children with 46 percent living in poverty and for elderly with 38 percent in poverty. The average payment for the typical welfare family of a mother and two children is $96 per month in Mississippi. The elderly suffer from malnutrition that contributes to debilitation which restricts their lives and may lead to a shorter life. The federal elderly nutrition programs have certainly assisted some elderly Mississippians—over 12,800 meals are served each day. However, this represents only 3 percent of the older population in our state. And please remember, 119,363 or 31 percent of Mississippi's elderly live below the national poverty guidelines. This percentage is by far the largest within the United States with the national average at 15 percent.

The federally funded Low-Income Home Energy Assistance Program (LIHEAP) and the Weatherization Program have assisted some Mississippians through our freezing winter. However, here again most poor Mississippians went unassisted. According to the 1980 Census, there are approximately 260,000 households that are eligible for assistance under these programs. Maximum utilization of program funds resulted in less than 30 percent or 70,000 of these eligible households being served last year.

I trust that, this morning, you went into the community and saw people facing these problems. I can assure you that Mississippi is filled with people who through no fault of their own, are in these financial straits—who suffer from hunger as a result of their poverty.

We call on you for assistance. You can increase the Food Stamp Program so that it more adequately meets the needs of the hungry. You can insure that successful programs like Head Start, WIC, Elderly Nutrition, Legal Services, and Community Action are kept strong so they can provide a resource for hungry people. You can give us programs that will enhance the opportunity of people to get jobs, adequate housing, health care and food so that our people can have pride. Our people are precious resources. If we have a commitment to human decency, if we have an understanding that our communities and our nation cannot afford to push a significant segment of the population beyond the reach of essential services, then we will fight to provide those services that will enable all to have an opportunity to live with decency and hope in their lives. We must be committed to this American ideal.

PREPARED STATEMENT OF JOHN A. FRAISER, DEPUTY COMMISSIONER, CLIENT/FIELD SERVICES, MISSISSIPPI DEPARTMENT OF PUBLIC WELFARE

Mr. Chairman, members of the select committee I am John Fraiser, deputy commissioner, client/field services with Mississippi Department of Public Welfare. I thank you for the opportunity to present a statement to this committee.

I will address two major programs, two cornerstones in the governments fight on hunger. They are the food assistance (food stamp) program and the emergency food assistance, program (commodities distribution program).

Mississippi is predominantly a poor, rural state. Our per capita income is last in the Nation at $7,725 per year and 52.7 percent of our population live in rural areas. Do we have people going to bed hungry in Mississippi? Yes: Have we made progress in raising the nutritional level of our populace? Yes: While we certainly have improved from the 1930's and 1940's, when starvation and malnutrition were prevalent, we do not have any frills in the programs, and there are problems with the programs.

The Food Stamp Act of 1964 was viewed as a major weapon in the war on poverty. It was to eliminate hunger and malnutrition through Federal supplements. The design was to eliminate the stigma associated with its predecessor, the commodities program. However, even though the program has helped, hunger is a real part of life for too many Mississippians. Too many children still go to sleep hungry with the knowledge that there will be no nourishment in the morning. Many elderly, who may not be eligible for any assistance, have to make basic decisions on whether to buy prescribed medicines or food. In my job, I hear countless cases relating stories like these on a daily basis.

The program, since its beginning, has been subjected to disapproval, controversy, and criticism. It has been maligned by the public, service consumers and policy makers as a program faught with fraud, errors, abuse and mismanagement. It has been the recipient of constant oversight and constant and continuous change.

The Food Stamp Program is the largest of the Federal food programs available to Mississippians. The program is state supervised, but service is delivered by 84 county welfare departments to almost 20 percent of the population. Just since 1981 the needs have grown significantly, the yearly allotment in dollars is up 15.44 percent and the number of persons receiving food stamps is up 3.38 percent in Mississippi.

But, even with the increased usage, not all possible eligible people participate in the program. Why?

Many consider the complicated eligibility determination process too difficult. Many are physically unable to wait in long lines to receive food stamps in areas where we have had to discontinue mail issuance. Many do not have transportation and public transportation is not available in many parts of Mississippi. Many feel the loss of pride, dignity and self-respect is not worth it. Some do not participate out of a lack of knowledge and some who might be eligible do not participate because they are frightened by perceived threats of prosecution or punishment. Some do not apply because the value they would receive is too small to help.

The more I see of the program, and I've been with the department for four years now, the more I'm struck by the change in the program. Our first food stamp manual was dated 1965 and contained 40 pages. Our 1983 manual is two volumes containing 978 pages and is growing daily. What a change!

More now, than ever, legislative and regulatory mandates to reduce error rates, identify ineligibles, and effect recoveries are with us. While there's nothing inherently bad about these goals, they have terrifically increased administrative costs and reduced benefits. Change to make a program efficient and effective is good. Change solely to effect budget reductions, in just one highly visible, controversial government sector, while other sectors go untouched, is another story.

In every year, the Food Stamp Program has been the target of some change in law. But, regulatory change has been even greater. In the past 30 months, there have been 90 changes of significance in the program.

The costs of these changes are great. With each new change FNS must rewrite its regulations, States must rewrite policy, staff must be retrained and recipients reeducated.

These changes not only cost to effect that revision, but the error rate, by which our performance is judged, goes up with every change. The changes have left the administrators, case workers and recipients frustrated, confused and bewildered.

What the program needs is stability. This program must continue as the cornerstone, but give time for the changes already made to show effect.

State administrators and county workers are just as competent and concerned with fraud, waste and abuse as are Members of Congress and USDA-FNS.

Many States believe strongly that sanctions are not needed to motivate them to reduce errors and detect fraud. Considerable effort and resources have been put in and will continue to be invested in improvements in these areas. New legislative approaches currently being considered, are seen by many as a negative approach. A simple change in philosophy from penalizing anyone over 5 percent to rewarding anyone over 95 percent may be a more palatable and desirable approach. Whether its called using the carrot and stick approach or drawing more flies with honey than with vinegar. The concept is far more positive.

The reduction and elimination of program abuse is a major concern of the States. We want to reduce errors and eliminate abuse. Many States have already developed innovative ways to correct abuse in the Food Stamp Program. The use of the 75 percent match fraud reduction has helped many to implement more aggressive programs in detection and recovery. Allowing States to retain a percentage of recovery has been a positive motivator. Training workers in probe interviewing and investigative techniques have shown very positive signs. Our error rate in Mississippi has dropped from 13.6 percent to 7.7 percent in the last several years.

Mississippi held 611 food stamp fraud hearings in 1982, compared to a national average of 226 (6th nationally). Fraud prosecutions totaled 365 in Mississippi compared to a 192 national average (12th nationally). Our administrative costs were $49.56 per case, this was the 48th lowest in the Nation. I believe this demonstrates we feel a commitment to reducing errors and reducing fraud without sanctions. In a State like ours with our workers already grossly overloaded who are working deligently to reduce errors and fraud, to impose a sanction on administrative costs would be a crippling blow.

With steady and significant progress being made in error rate reduction and with every reasonable and good faith effort being made, sanctions still loom ominously on the horizon. If we were to have to suffer a reduction in administrative funds, we would have no choice but to reduce staff. This would result in an even larger workload to be handled by fewer staff, which would in all probability result in higher error rates and further penalties. What a vicious cycle. These are not just negative fantasies, but potential realities.

Many other problem areas with this program, such as mail issuance tolerances, uniformity in eligibility determinations among programs involving household definition, budgeting, resources and income determinations, MR/RB, uniformity of quality assurance regulations and policy with eligibility determination of caseworkers, and matching rates for systems development could be discussed here and have been discussed at length by many. However, let me say that the Food Stamp Program has made a significant contribution to not only the recipients, but to Mississippi's economy. It must remain the cornerstone and we must offer people the choice to satisfy the most basic physiological need—to eat. The program should be run efficiently, as should all programs, but let's recognize the progress and improvements that have been made so far and strive in a positive vein to further improve this program.

Now, let me address the Emergency Food Assistance Program, or as we title it in Mississippi, the Food Distribution Program. This is a program that has provided an excellent supplement to the Food Stamp Program and one which we are witnessing rapid growth in, not only in Mississippi, but the Nation. We are seeing increased allocations in products and increased varieties in products, and all the products are distributed and used. There simply must be a need for the food.

In July of 1983 the Mississippi Department of Public Welfare was highly encouraged to assume the responsibility for the operation of the commodities distribution program for Mississippi. We agreed to take on that new role knowing that it was a big job and one that would likely increase in size, scope and complexity. Our expectations have already been fulfilled, with further likelihood that they will be exceeded.

Up until the time that we took over the responsibility for the program, it was handled by the Governor's office of Federal-State programs who worked with the planning and development districts, the boards of supervisors and the State and county welfare departments. We have from the inception been closely involved in this program and have supplied personnel to run the program with no reimbursement for their time and sometimes at the expense of our other program areas.

The Commodity Distribution Program, until now, was loosely run, I mean, it was simple. There were few guidelines, little requirements for reporting and less accountability requirements. However, it is my opinion that generally speaking, the food was provided to needy people with little waste and abuse. The program was administered well, as conceived at that time.

However, since that time, the regulations, reporting requirements, accountability requirements, allocations of products, and the processes of certification and eligibility have multiplied, resulting in greatly increased administrative costs, and a greatly increased burden on our already overworked and understaffed county offices. We will run the program, but there does come a time when one cannot ask his people to do more with less. The myriad requirements, most of which we are told are due yesterday, can only lead to further increased costs. One cannot help but wonder if the costs of administration are greater than the dollars that might be lost through loss, shrinkage, waste, or abuse in the process of distribution of the products when the program was simpler. This program has not yet reached the level of complexity of the Food Assistance Program (Food Stamps). We will be able to handle this program if we are not overburdened with Federal regulations. This program must be kept as simple as possible while remaining accountable too.

We are experiencing growing pains with this program. When an operation involves working with and depending on as many different agencies as this one does (including USDA, Food and Nutrition Service, Commodities Credit Corporation, private storage firms, private trucking firms, boards of supervisors and 84 county welfare departments among others), problems come up. We have experienced problems with late delivery dates on products from CCC, trucks being late to delivery sites, too much or too little for county allocations, and storage problems. Additionally, some of these people have to pay $10-$15 in transportation costs to get to the distribution sites to receive their $20 worth of commodities. These are problems that will take the work of eveyone to improve. There are no easy solutions to this program.

Complaints about long waits in line have surfaced during the past distributions. While we think we are doing a good job, we know one can improve the distribution process.

We experimented with a voucher system in Hinds County during a recent distribution. It worked and it has been implemented in all of our counties. However, the change to the voucher system is only a part of the process of faster distributions and shorter waits in line. Keeping regulations and requirements for eligibility, certification, reporting and accountability is the bigger part of the solution in making the process less burdensome on the people who benefit from receiving the food and less cumbersome on the people who must operate the program.

Probably, the one area in which we received the most comments on was concern to include the elderly in the distribution. Our charge was to get the food to the needy: we have done that and numbers of elderly were among those people receiving food. However, we must continue to insure that the distribution of food keeps a relation to income, resources and need. But, we are looking at volunteer help to assist in the picking up and deliverying of food to the elderly, sick and disabled so that we are able to distribute food to them in a manner that is easiest for them. We are comfortable with the progress of this program so far, and will continue to work diligently to further improve the program operation.

We are committed to this program because we know it is greatly needed and is serving a terrific need, not only in Mississippi but in the Nation. One only has to go to a distribution site and see the thousands of people waiting in line for $20-$30 worth of cheese, butter, rice, flour or other products to understand this food is needed by the needy. During our distributions we distributed commodities to nearly 165,000 households each time. During the next year, at our present allocation levels, we will distribute over $17,000,000 worth of food products during our expected 4-6 distributions.

Lastly, let me point out that there will always be very significant costs associated with this program. We have not yet charged, nor do we expect that we will be able to charge for our workers time. But there will be costs for storage, trucking, security, loaders, equipment rentals and many other areas. These are costs that we are now receiving 100 percent Federal reimbursement for and for which that level must be continued. Our counties and our State cannot afford to take on any increased costs of new programs. This is a national program that must continue to be funded at the 100 perent level and at levels which will insure that the States can buy the help needed to distribute the food.

PREPARED TESTIMONY OF DONALD B. ROARK, PH.D., COMMISSIONER, MISSISSIPPI DEPARTMENT OF PUBLIC WELFARE, AND CHAIRMAN, FOOD STAMP COMMITTEE, NATIONAL COUNCIL PUBLIC WELFARE ADMINISTRATORS, BEFORE COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY, U.S. SENATE, OCTOBER 18, 1983

Mr. Chairman and distinguished members of the subcommittee, my name is Donald B. Roark. I am Commissioner of the Mississippi Department of Public Welfare. I also have the privilege of serving as chairman of the Food Stamp Committee of the National Council of State Public Welfare Administrators.

On behalf of the approximately 25 percent of Mississippi's population who receive food stamps, and on behalf of the chief state executives responsible for administering the Food Stamp Program, I appreciate this opportunity to speak to you this morning on what the impact has been of legislative and regulatory policy changes designed to reduce fraud, waste, and abuse in food stamps. This Subcommittee has always eagerly sought the perspective of those of us on the operating end of the program, with the aim of ensuring the workability of federal legislation. I hope the comments I make today will ably serve this purpose, through constructive suggestions to you to stabilize and further improve the Food Stamp Program.

A sluggish economy and budget deficits the past several years have served to highlight the need for program reforms designed to improve the administration and cost effectiveness of food stamps while preserving the nation's commitment to feed the poor. Since the 1977 reform of food stamps, numerous efforts have been made to combat fraud, abuse, and waste in this large, complex program. The significant attention and high level of resources devoted to eliminating these problems have significantly improved the ability of federal and state administrators to deter and detect program violations. In addition, the success that has been achieved in this area, has begun to improve the program's image in the public eye.

No single change or requirement can be given all the credit for the reduction of fraud, abuse, and waste we are witnessing in the Food Stamp Program. What is happening is the cumulative effect of sophisticated and innovative applications by the states of information processing, public education and awareness, and cooperation between the three levels of government to ensure that program benefits are used as intended by Congress.

PROGRAM MANAGEMENT

As chairman of the State Welfare Administrators' Food Stamp Committee, I have the pleasure of working closely with program managers from nearly every state. The Committee serves as a clearinghouse for disseminating information and identifying and resolving issues of mutual concern. Through our work for the Council, the state administrators have often supported or proposed program changes we believed would improve the overall program performance. Without doubt reforms enacted over the last several years have greatly enhanced our ability to provide nutrition assistance to the needy efficiently and effectively.

Speaker as Mississippi Commissioner, and for the Nation's welfare administrators, I come today to urge that you and your colleagues in Congress make as few changes as possible in the Food Stamp Program. In our judgment, what the Food Stamp Program needs most of all now and deserves, is STABILITY—A period of rest from legislative and regulatory reform.

As administrators we know there is always some aspect of the program that could stand improvement. However, it is the Council's belief that another round of changes, adding to program administrative requirements at this point would prevent us from getting the most out of the measures already enacted. However, we also believe that something can and should be done to alleviate certain problems which cause unnecessary administrative costs and burden. These relate to: (1) unrealistic implementation schedules; (2) monthly reporting and retrospective budgeting; and (3) unreliable program preformance measurements.

Over the last two and a half years, hasty implementation of congressionally mandated changes has actually increased costs and errors. The time available to states for implementation directly affects the states' ability to fully implement, let alone evaluate program changes. USDA's frequent use of interim final rulemaking that precludes public involvement in the regulatory process, forces states to take ill-advised short-cuts in implementation, Fast track implementation prevents full and through staff retraining, policy analysis and reworking, adequate computer reprogramming, recipient re-education, and in turn is the root cause of many avoidable errors that a more reasonable approach would prevent.

MONTHLY REPORTING AND RETROSPECTIVE BUDGETING

Monthly reporting and retrospective budgeting (MR/RB) has not been the panacea the administration had hoped. In 1980, Congress enacted legislation making monthly reporting and retrospective budgeting systems a state option in the Food Stamp Program. However, in 1981, Congress reversed gears and—at the request of the Administration—made the use of these systems a mandatory federal requirement (rather than a state option) after October 1, 1983.

Today, this requirement is causing serious problems for many states across the country, Numerous states have found these systems to be cost-ineffective and expensive to administer. Findings recently made available from a number of federally sponsored demonstration projects provide hard research data to confirm that monthly reporting and retrospective budgeting system generally do not reduces errors—but do increase administrative costs and result in the denial of benefits for some needy families.

In recent months, 32 state public welfare administrators signed a mailgram. The text of that mailgram is attached to my testimony. Many other state welfare directors are also opposed, but could not be reached in time to affix their signatures, asking Congress to make monthly reporting and retrospective budgeting a state option rather than a mandate imposed by the Federal Government. These states have asked to be trusted with the flexibility to utilize monthly reporting where it would be effective—but to direct their resources toward other management techniques where other approaches are likely to be more successful in reducing errors and costs.

As a partial response to these state requests, the Congress on September 30 placed a provision in the Continuing Resolution which extended for 90 days the October 1, 1983 deadline on which the mandatory federal requirement takes effect. However, a 90 day extension will not make the basic problem disappear—the problem that monthly reporting and retrospective budgeting systems simply are not effective in some areas and do increase administrative costs and paperwork burdens.

In addition, since the September 30 consideration of this issue, major new evidence on this matter has become available. Results have just become available from the only demonstration project on monthly reporting and retrospective budgeting ever conducted in the Food Stamp Program, a major pilot project in Illinois. The results show that not only did monthly reporting fail to reduce error rates or benefit costs in the Food Stamp Program, but benefit costs actually increased by 8 percent. Even more shocking, administrative costs skyrocketed, rising 20 percent. The research notes that these high added costs associated with monthly reporting were linked to a series of implementation problems, problems that could occur in other areas as well unless monthly reporting systems (which are very complex to operate) are thoroughly tested and "de-bugged" first. The study found that even if the system had operated without problems, it still would have caused increases in administrativea costs, and that there is not evidence to show that any offsetting benefit saving would be realized.

Testifying before this Subcommittee, in March 1981, the late late Jack Dempsey said, "Manadatory retrospective accounting presumes a uniformity of administration and household circumstances that simply does not exist." State experiences and the information from the limited studies of MR/RB indicate it can be a wasteful mis-use of program dollars. In May of this year, former Senator Henry Bellmon, who served on this committee, and was then Oklahoma Director of Human Services said: "While Oklahoma has had some success with monthly reporting and retrospective budgeting in AFDC, it is our opinion the same process will not be effective in the Food Stamp Program and will, in fact, be a costly and difficult administrative process. Beyond the question of administration, retrospective budgeting has caused some unnecessary hardship for recipients because it computes currrent benefits on income received one or two months ago whether or not their income is still being received."

The states' opposition to mandatory MR/RB is not a reluctance to invest state funds in reducing fraud. As public administrators, we are responsible for the orderly and efficient operation of the programs under our jurisdiction paid for by tax dollars. Fraud, waste and abuse in these programs is a major concern because it is symptomatic of programs out of control. In our view, MR/RB does not constitute an effective deterrent to fraud.

States need to know now what Congress' intentions are in this area. States cannot wait 90 days and find out at the last minute whether Congress will extend the mandatory deadline again. Preparations to implement this provision, or to move to alternative management techniques, must be made now in many States. We believe the dollars and sense choice is clear. The law should be amended to return MR/RB systems to the "state option" category.

After years of pilot testing these systems in AFDC and food stamps, there is no evidence that they reduce errors or costs. Many Members of Congress are fond of saying that some well-intentioned social programs simply have not worked as intended and need to be altered. Monthly reporting/retrospective budgeting systems are examples of management techniques to reduce errors that, although similarly well-intentioned, also have not worked out.

Congress, in 1982, adopted the chairman's proposal for a graduate error rate reduction system. The sanctions that would be levied against the states for failure to reach the error rate targets will cost states millions of dollars—millions of dollars that should be spent providing services to the citizens of the states.

The Council reaffirms its belief that financial penalties are not needed to spur states towards better program management. Good management, well run and cost effective programs are in the states' interest. Considerable state resources have been and continue to be invested in program improvement. However, if fiscal sanctions must be included as an integral part of the Food Stamp Program, a reliable and statistically valid means of assessing errors is needed immediately.

We have identified over the years three major weaknesses of the current quality control system used to measure program errors: (1) it does not produce valid estimates of real errors; (2) information is not produced in a timely fashion to permit effective corrective action; and (3) states that have performed well are often penalized. Although USDA has recently proposed revised quality control rules, we believe the states concerns should be fully resolved before any move to publish them in final form. IF the states are to be penalized based on measurements of dubious validity, then the states should also have ample opportunity to comment and input.

The State administrators have prepared legislative language that we believe would put the quality control system on the right track by creating a uniform error measure system for Medicaid, aid to families with dependent children [AFDC] and the Food Stamp Program. Our proposal would require a joint study by the Secretary of Health and Human Services and the Secretary of Agriculture concerning the current QC system. While the study is being conducted, we propose a suspension of all fiscal sanctions. Following the completion of the report and state comment, regulations would be developed for the Food Stamp Program modifying the current system in favor of uniform QC system for income support programs. If errors are truely to be controlled, we must be certain that errors are properly identified and measured.

FRAUD, WASTE, AND ABUSE

The reduction and elimination of program abuse is a special concern to State administrators. We believe, that combined use of the many provisions in law designed to make the program less prone to violations, is having a very positive effect. Our commitment to this effort is no less than our ongoing battle to reduce program errors.

The States have devised some very unique programs to combat program abuse. Federal financial assistance through 75 percent matching funds for fraud reduction efforts has helped make it possible for States to implement aggressive programs. In addition, allowing States to retain a percentage of collected claims overissuances has certainly been an incentive for greater efforts in this area. States have used these funds to upgrade and enlarge their investigative staffs. Eligibility workers are also trained in investigative techniques making them an integral part of antifraud programs. As a result, most States can report that collections have increased almost ten times.

Several States have increased their computer capability and thus are better able to maintain files on program violators and prevent them from receiving benefits simply by moving around the State. Statutory changes such as allowing States to reduce household allotments to collect overpayments, stiffer disqualification penalties for households and retailers have improved the program administrators' ability to deter and prevent repeat abuses. Computer matching is another valuable tool. In most instances the State can obtain timely information used to verify client provided income reports. As we become more proficient in the use of computer matches by targeting select categories of recipients or making it a routine part of recertification, more overissuances will be recovered, and we will make it less attractive for clients to make that initial false report.

Thank you for your attention to our concerns. The Council remains committed to assisting this committee in the improvement of the program.

To: The Honorable Margaret Heckler, Secretary, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201.
The Honorable John R. Block, Secretary, U.S. Department of Agriculture, 14th Street and Independence Avenue, SW, Washington, DC 20250.

As state public welfare administrators, we are requesting that you support our efforts to amend existing statutes pertaining to mandatory implementation of Monthly Reporting and Retrospective Budgeting (MR/RB). It is the consensus of the states that MR/RB should be a state option rather than a mandatory administrative process.

MR/RB can be costly to implement, especially in light of limited federal and state resources. Additionally, the problems experienced to date in implementing AFDC caseloads will increase substantially as states begin to include their Food Stamp caseloads in the MR/RB process.

We are extremely concerned about the effect of MR/RB on our error rates. We had already achieved considerable success in curbing our error rates prior to the imposition of mandated MR/RB. Now, at a time when we are faced with diminishing resources and the possibility of fiscal sanctions, we are forced to use an unproven alternative. It is our contention that we must be allowed to administer the AFDC and Food Stamp programs in ways best suited to our varied caseload and administrative characteristics.

For the reasons above, it is the consensus of the states that the following legislative proposals be enacted:

Make monthly reporting and retrospective budgeting optional to the states in AFDC and Food Stamps.

Expand the waiver authority to permit compatibility among AFDC, Food Stamps and Medicaid.

Place a moratorium on counting quality control errors caused by the implementation of MR/RB.

Copies of this telegram are being shared with key Congressional Leaders, in particular, members of the House Ways and Means. Senate Finance and House and Senate Agricultural Committees. We hope that you will actively support our position on these important issues.

Leon Frazer, Alabama; Kenny Whitlock, Arkansas; George Goldstein, Colorado; Stephen Heintz, Connecticut; James Buford, District of Columbia.

David Pingree, Florida; James Ledbetter, Georgia; Franklyn Sunn, Hawaii; Thomas Purce, Idaho; Jeffrey Miller, Illinois.

Donald Blinzenger, Indiana; Michael Reagen, Iowa; Robert Harder, Kansas; Joseph Gallant, Massachusetts; Agnes Mansour, Michigan.

Leonard Levine, Minnesota; John LaFaver, Montana; George Albanese, New Jersey; Joseph Goldberg, New Mexico; Cesar Perales, New York.

John Syria, North Carolina; John Cuddy, Ohio; Henry Bellmon, Oklahoma; John Crosscope, Jr., South Carolina.

James Ellenbecker, South Dakota; Sammie Lyn Puett, Tennessee; Marlin Johnston, Texas; Andrew Gallegos, Utah.

James O'Rourke, Vermont; Alan Gibbs, Washington; Leon Ginsberg, West Virginia; Linda Reivitz, Wisconsin.

PREPARED STATEMENT OF JOHN R. BARR, DIRECTOR, MISSISSIPPI WIC PROGRAM, MISSISSIPPI STATE DEPARTMENT OF HEALTH

My name is John Barr and I am the director of the Mississippi WIC Program.

As you know, the Special Supplemental Food Program for Women, Infants and Children (WIC) is a totally federal funded program administered by the U.S. Department of Agriculture through the departments of health in each state. In addition, the program is offered in Puerto Rico, the Virgin Islands, Guam, the District of Columbia, and through 31 Indian tribal organizations.

In Mississippi we are able to serve more people with funds we receive because of our unique system of providing a food package directly to the client. Through a network of 88 distribution centers throughout the state, participants pick up a food package monthly from a local distribution center in their county of residence.

By letting bids for the food products each quarter, we are able to purchase our food at much less than the retail price, or about $9 less per food package that other states. Therefore, for every three persons enrolled, one additional person can be served with the savings realized. We now serve over 87,000 persons each month, or 57 percent of the potentially eligible women, infants and children in the state. Because our 1984 grant will not sustain this number of persons, we are now taking steps to reduce our caseload by lowering the income guidelines to 133 percent of poverty from 185 percent. This action is expected to reduce the caseload to about 84,000 persons per month by September, 1984. Future reductions or increases will depend on the appropriation for fiscal year 1985.

In the materials I furnished the Committee prior to this hearing is a position paper developed by the National Association of WIC Directors at our February, 1984 meeting. While we believe all of the issues addressed to be important; in the interest of time, I will only discuss several of the most pressing ones.

Since WIC was provided partial year funding of $1.06 billion under the Continuing Resolution, the $300 million supplemental funding for July 10, 1984 to September 30, 1984 must be appropriated very soon to avoid major program disruption.

State WIC Programs should be authorized end-of-year funding flexibility, not to exceed 3 percent, to permit the most effective management andutilization of total funding. There are many uncontrollable variables which enter into the management of the program which make it difficult to utilize 100 percent of funding without the risk of overspending. At this time, the only alternative for program managers is to cut caseload toward the end of a fiscal year when there is a possibility of overspending. With authority to exceed the grant from 1-3 percent, with a corresponding reduction in the following year's grant, states would have management flexibility which will allow for program stability.

I urge your support of this authority.

We recommend expanding the annual program authorization level by an amount equal to the determined inflationary increase plus 10-15 percent real growth in 1985. While this might seem excessive in light of current budget deficits, we believe the program to be cost-effective and by meeting this need may contribute to significant savings in future medical costs. While no major studies have been completed on the effects of the WIC Program in Mississippi, one of the major goals of the program—to improve the health and nutritional status of infants and children—is certainly being met. In 1975, one year after WIC came to Mississippi, the infant mortality rate was 22.5 deaths per 1,000 births. In 1982, seven years later, that rate had been reduced to 15.4 deaths per 1,000 births—and Mississippi no longer leads the nation in infant deaths. Other statistics, such as low birth weight and low gestational age infants have likewise been reduced.

While the WIC Program does not claim full credit for these improvements, the impact of the program is evident. Of the almost 46,000 live births in Mississippi in 1982, the program provided service to over 40 percent of those mothers.

Non-food program costs should be defined as direct services and operational costs which includes nutrition/health assessments and nutrition education, plus local and state administration.

Presently, the annual grant is divided into two categories—food and administration. Recent proposals to cut costs by reducing the percent of the administrative grant from 20 percent could be devastating to the program.

We believe the term "administrative costs" to be a misnomer since these also include payment for many client services such as nutrition/health assessments and nutrition education, plus local and state administration. In Mississippi, our administrative costs also include the rent and utilities for warehouse space which is included in the cost of food in other states. Therefore, we respectfully request the definition of administrative costs be expanded to identify the other services provided with the monies and that the minimum funding for direct services and operational costs should be 20 percent of the total grant.

Finally, I would like to thank the Congress for the past support provided the WIC Program and assure you of my commitment to responsibility manage the program to the benefit of those women, infants and children in Mississippi who need our service.

NATIONAL ASSOCIATION OF WIC DIRECTORS—A STATEMENT OF CONCERNS

SUMMARY OF RECOMMENDATIONS—MARCH 9, 1984

Legislative authorization:

1. The special supplemental food program for women, infants, and children (WIC) should be given permanent authorization prior to September 30, 1984.

2. There should be no targeting of program benefits beyond the revised proposed federal regulations issued July 8, 1983 (Par. 246.7(d)(4) alternative C).

3. Non-food program costs should be defined as "direct services and operational costs which includes nutrition/health assessments and nutrition education, plus local and state administration."

4. The minimum funding for direct services and operational costs should be no less than 20 percent of the total grant.

5. There should be no establishment of a limitation on "state agencies" based solely on minimum participation levels.

6. Administrative type rules such as "processing standards" and "public hearings" should be provided for in federal regulations rather than legislation.

Legislative funding:

7. The full commitment of $300 million fiscal year 1984 supplemental funding should be honored, with the funds provided far enough before July 10, 1984 to avoid program disruption.

8. The fiscal year 1985 appropriation should be sufficient to allow 10 percent-15 percent increase in the WIC caseload.

9. Authorization for end-of-year funding flexibility, not exceeding 3 percent, should be granted to permit the most effective management and utilization of total funding.

10. The special supplement food program for women, infants, and children (WIC) should continue as a catagorical program rather than folded into a block grant.

The National Association of WIC Directors represents the state agency WIC directors of all the fifty states plus 31 Indian tribal organizations, Puerto Rico, the Virgin Islands, Guam, and the District of Columbia. It was first conceived in 1979 as a national forum of dedicated program managers and other interested persons to act collectively on behalf of the Special Supplemental Food Program for Women, Infants and Children (WIC). It was officially organized by the adoption of its bylaws in November 1983 and the election of officers at its first national conference, February 6-9, 1984.

The functions of the Association include, but are not limited to, the following specific functions:

A. To act as a resource for governmental bodies and individual legislators regarding issues particular to the health and nutrition of women, infants and children and to act as an advocate for WIC clients.

B. To provide good management practices to assist WIC Program Directors at the State and local levels.

C. To provide a national resource network through which selected ideas, materials, and procedures can be communicated to persons working in the WIC community.

The Association recognizes that this, the 10th anniversary year of the WIC Program, is one of the most critical years. Its legislative authorization expires September 30, 1984. Though federal funding of the Program has been relatively generous in the past, it must continually seek adequate funding even in years of high federal deficits.

As we celebrate its 10th anniversary, we commend the great accomplishments it has effectively attained since its establishment by a wise and concerned Congress faced with the probable effects of malnutrition in the lives of women, infants and children in our country.

Though the U.S. General Accounting Office's (GAO) most recent report on WIC evaluations released January 30, 1984 stated there was no "conclusive evidence" on the effects expected for the WIC Program, it did affirm that the WIC evaluations did provide some favorable effects of the Program. Among the GAO findings were:

We estimate that WIC decreases the proportion of low birthweights for infants born to women eligible for WIC by 16 to 20 percent. WIC's effect on mean birthweights also appear to be positive . . . WIC mothers appear to experience greater benefit the longer they participate.

We conclude tentatively that teenage women and black women who participate in WIC have better birth outcomes than comparable women who do not participate in WIC.

Participating in WIC may mitigate some of the effect of a mother's smoking, demonstrably harmful to infant birthweights.

The available evaluation evidence is modest and preliminary but suggests that participation in WIC improves the intake of energy, protein, and some other nutrients for pregnant women, enhances the iron in their blood, and increases their weight gain.

The limited evidence on anemia from the two studies of moderate quality suggest that WIC may reduce the incidence of anemia among infants and children.

The Missouri WIC evaluation study cited by the GAO review as one of the most credible and qualitative WIC evaluations documented that: "For both non-white and white participants, the low birthweight rates were less than one-half of the rates for comparable non-WIC mothers." This is a particularly significant finding because infant mortality is the 12th leading cause of death in our country and a low birthweight infant is 20 times more likely to die than a normal one.

That the GAO report could not be more conclusive was not necessarily indicative of deficiencies within the Program. The "lack of conclusive evidence" was more a problem of the size of the studies (State studies vs. National) and particular methodological imperfections (difficulty establishing a control group). The GAO, itself refers to these problems in underscoring "the need to design and implement better studies."

Confident that the WIC Program has earned its place in the field of preventive health, the National Association of WIC Directors has chosen this means to address itself to the basic concerns of legislative authorization and funding as the Program begins its second decade servicing the health and nutrition needs of women, infants and children.

Herein is our statement of concern.

Legislative authorization:

1. The Special Supplemental Food Program for Women, Infants and Children (WIC) should be given permanent authorization prior to September 30, 1984.

The National Association of WIC Directors (NAWD) earnestly believes that the Special Supplemental Food Program for Women, Infants and Children (WIC) should be granted permanent authorization. The logic for such belief is based on sound management principles and the need for administrative continuity. It is most disruptive for any program to have to deal with legislative and regulatory changes each year. In many cases, it takes the greater part of a year to implement such changes. It is especially disruptive to a program such as WIC wherein certification is valid for a six month period. By the time some of the changes are fully implemented in the first cycle of certifications, there is a cloud of uncertainty over those certifications made during the last half of a one year authorization. The overall effect produces a negative climate of uncertainty at the local agency level regarding program stability. For possibly the first time in its ten years of existence, WIC finally has a method of funding and a fairly well refined set of federal regulations which assure some continuity and reflect some degree of long range planning. Therefore, the Association, confident of the effectiveness and proven national acceptance of the Program, recommends permanent authorization.

2. There should be no targeting of program benefits beyond the revised proposed federal regulations issued July 8, 1983 (par. 246.7 (d)(4) alternative C).

There are those who suggest that WIC should better target program benefits to "those most-in-need". The "most-in-need" generally connotes "those who are identified as exhibiting some type of medical, anthropometric, or hematological risk." This argument compromises the entire *preventive* nature of WIC. It argues that WIC should be primarily therapeutic in nature. We find this troublesome. During the past ten years, health care literature has continued to support the premise that prevention of health problems is *cost-effective* as well as humane. This has been shown in both the public and private sector. To limit WIC to therapeutic treatment would be short-sighted and would only contribute further to our current national dilemma, the continuation of spiraling health care costs.

The July 8, 1983 proposed Federal Regulations [Par. 246.7 (d)(4) Alternative C] governing the WIC Program provide for a priority system to manage caseloads. State directors believe that relatively slight revisions in that proposed priority system would ensure that those participants at greatest risk receive WIC services. Therefore, the National Association of WIC Directors recommend that there be no targeting of benefits beyond the revised proposed Federal Regulation.

3. Non-food program costs should be defined as direct services and operational costs which includes nutrition/health assessments and nutrition education, plus local and State administration.

Those who propose to reduce the WIC Program administrative costs because they appear too high compared to other public assistance programs apparently have a misperception of what is included under program administration.

Indeed, "administrative costs" is really a misnomer since these also include payment for many client services such as nutrition/health assessments and nutrition education, plus local and state administration which includes safe-guarding accountability of federal dollars. If such a broad definition of "administrative costs" were applied to many health service programs, one could say their costs are 100 percent administration.

Revision attached as addendum to this paper.

The National Association of WIC Directors recommends a redefinition of "administrative costs." Allowed non-food costs are better defined as: "Direct services and operational costs which include nutrition/health assessments and nutrition education, plus local and state administration."

4. The minimum funding for direct services and operational cost should be 20 percent of the total grant.

The more definitive statment regarding direct services and operational costs, emphasizing the significant inclusion of client services, refutes the argument of high administrative costs. In fact, it can be more justly argued that the WIC Program is remarkably efficient. It provides more services than other programs at lower cost.

To help stretch limited Federal direct services and operational cost dollars, State and local governments have contributed in-kind resources. A 1978 survey of State and local WIC Programs found that State and local in-kind contributions (staff, office spaces, etc.) comprised 13 and 40 percent of total State and local costs. However, as State and local public health budgets and Federal funds for maternal and child health services have shrunk over the past three years, the ability to provide in-kind resources to WIC has eroded. At the same time the purchasing power of direct services and operational funding has likewise eroded because health care costs have risen faster than food costs, the base of the 20 percent direct services and operation cost funding.

WIC directors are concerned about present and future cost containment. We believe that WIC Program services are an investment in preventing higher medical expenses. Studies in Massachusetts and Missouri have shown that infants of WIC participating women have lower medical costs than infants of comparable non-WIC women. These medical savings more than offset the costs of the WIC Program food and services. WIC not only promotes good health, it saves money.

These services can only be maintained if direct services and operational funds are sufficient to pay staff and to keep clinics open. The factors above have forced WIC managers and staff to retrench in providing services already. Any further funding restrictions will reduce the effectiveness of the WIC Program in serving needy women, infants and children and may ultimately lead to higher medical costs.

Therefore, the National Association of WIC Directors recommends that the minimum funding for direct services and operational costs be no less than 20 percent of the total grant. The Association believes that even a higher percentage is justified but it leaves that decision to the wisdom and good will of those who are empowered to decide.

5. There should be no establishment of a limitation of "State agencies" based solely on minimum participation levels.

Those currently supporting a minimum size requirement for state agencies use "high levels of administrative cost" as the argument against small state agencies. In reality, the only state agencies likely to be affected by such a requirement would be those operating programs for Native Americans. If actual dollar amounts were reviewed rather than percentages, it would reveal that the number of dollars are relatively small. For example, if we look at the Miccocouk State Agency, we observe a direct services and operational costs/food ratio 46.33 percent. But dollars reflect $34,309 for food and $15,131 for direct services and operational costs. We feel that limiting state agencies to minimum sizes would only affect services to Native Americans. Since Native Americans have unique nutritional needs and problems, we do not feel services to this population should be sacrificed for the sake of minimal affect (in real dollar amounts) upon direct services and operational moneys.

6. Administrative type rules such as "processing standards" and "public hearings" should be provided for in Federal regulations rather than legislation.

As state directors, we greatly appreciate the concern of advocacy groups that seek to more effectively control program management by writing detailed client safeguards into enabling legislation. We are equally concerned about possible rapid and dramatic deregulation which could erode the quality of the Program. As program managers, we see the question to be how to maintain quality control in the Program, without over controlling the Program so that it cannot be managed efficiently.

We are committed to ensuring effective, efficient benefits to participating clients in a most timely manner; however, we are troubled by what are sometimes unrealistic processing standards, particularly in smaller satellite clinics established primarily as a convenience to the clients, by providing services in close proximity to where clients live.

We are in favor of public input into state plans; however, history has proved that legislated public hearings are not effective. Participation at hearings often involve less that five persons, with some hearings actually attracting no one.

It is the opinion of the National Association of WIC Directors that these administrative policies can better be addressed through Federal Regulations which can more effectively provide proper guidelines with greater flexibility. State agency directors are committed to the established goals of the Program and believe that with more flexibility they can pursue the attainment of the goals in a creative, responsible manner.

Legislative funding:

7. The full committment of $300 million fiscal year 1984 supplemental funding should be honored, with funds provided far enough before July 10, 1984, to avoid program disruption.

To avert a severe crisis in the summer involving the possible dropping of approximately 1,000,000 participating clients during July, August and September, the commitment of $300 million supplemental funding must be appropriated far enough before July 10, 1984 to avoid program disruption. The need is so obvious, WIC directors cannot rationally conceive that anything less than the full commitment of Congress will be provided. We commend the clear, definitive statement of the Congressional intention as expressed in passing the Continuing Resolution.

8. The fiscal year 1985 appropriations should be sufficient to allow a 10–15 percent increase in WIC caseloads.

The National Association of WIC Directors applauds the past support which has been provided for the WIC program. We believe the Program has proven the merit of such wisdom. As we look to the future and the beginning of the Program's second decade, we beleive that its future funding must be related to both need and cost-effectiveness.

The Congressional Budget Office (CBO) has stated that $1.47 billion will be need to maintain current WIC caseload levels throughout fiscal year 1985. Obviously, the fiscal year 1985 appropriations should be no less than that projected by the CBO.

However, we are sensitive to the great number of persons in need of the Program benefits and who are potentially eligible for Program participation which we cannot serve due to limited funding. We are equally aware of the necessary tension between program expansion and budget deficits. There is no easy course. Hard decisions must be made.

As state agency directors, we feel we would be irresponsible if we failed to emphasize the great need to expand the Program during the next few years in an orderly, reasonable manner. We recommend expanding the annual program authorization level by an amount equal to the determined inflationary increase plus 10–15 percent real growth per year. The real growth increase would complement the Department's present funding formula to establish equity based on need among the states and would permit limited growth in the stablished state agencies.

This proposal is made in good faith that it will be a positive factor in controlling future deficits.

The GAO review of the most credible WIC evaluations led them to estimate 'that WIC decreases the proportion of low birth-weights for infants born to women eligible for WIC by 16 to 20 percent.' The Missouri study cited by GAO documented that 'For both nonwhite and white participants, the low-birthweight rates were less than one-half of the rates for comparable non-WIC mothers.' Further evidence of WIC's positive effect in preventing more costly long-term medical and health costs are cited within the GAO report.

It is true that the report stated there was no conclusive evidence on the effects of the Program though it did clearly state that 'the information indicates the likelihood that WIC has modestly positive effects in some areas.' That the GAO report could not be more conclusive was not necessarily indicative of deficiencies within the Program limiting its intended effectiveness. The 'lack of conclusive evidence' was more a problem of the size of the studies (state studies rather than national) and particular methodological imperfections (such as difficulty in establishing a 'control group'). The GAO refers to this problem in underscoring 'the need to design and implement beter studies.' It must be remembered that it was the studies cited by GAO for their quality and credibility that documented the positive outcomes referred to in this paper.

Thus, as directors, we believe that Program expansion providing positive benefits may contribute to significant savings in future medical costs. This would have a positive effect on reducing future deficits. We welcome the opportunity to be a partner in the national search for a resolution of our common fiscal problems.

9. Authorization for end-of-year funding flexibility, not exceeding 3 percent, should be granted to permit the most effective management and utilization of total funding.

Due to many uncontrollable variables, it is most difficult, if not impossible, to utilize 100 percent of funding without risking overspending during the last 30-60 days of the fiscal year or cutting participation in that period to prevent overspending. For a State to perform at less than 100 percent is to deny services to those who need program benefits. Likewise, to under-utilize total funding because of imprecise control over variables could be interpreted that Program funds are adequate or greater than need, and could cause unwarranted reductions in future funding. Therefore, the National Association of WIC Directors recommends that the State agencies be authorized to exercise management flexibility for end-of-year funding to exceed the grant by no more than 3 percent without penalty.

10. The Special Supplemental Food Program for Women, Infants, and Children (WIC) should continue as a categorical program rather than being folded into a block grant

The National Association of WIC Directors has testified twice before Congressional Committees against consolidation of WIC and the MCH Block Grant (the Senate Subcommittee on Nutrition, February 22, 1982 and the House Subcommittee on Elementary, Secondary, and Vocational Education, March 17, 1982.) The points raised in the testimony still apply and have been reaffirmed by the Association. We stand firmly on our belief that WIC's continued support has been a result of its ability to be identified as a specific service and to account for its effectiveness upon the nutritional well-being of women, infants and children. To those of us convinced that WIC will continue to prove its impact upon the health of our nation's children, such identity is imperative.

* * * * * * *

The National Association of WIC Directors has submitted these recommendations as a resource for governmental bodies and individual legislators with confidence that their consideration and adoption will enable the Special Supplemental Food Progran for Women, Infants and Children (WIC) to effectively continue as one of the most successive preventive health programs ever established by Congress. As directors we commit ourselves to responsibly manage the Program and safeguard the accountability of Federal funds in order to provide maximum benefits to those women, infants and children who are at nutritional risk in our country.

Respectfully submitted by,

C. Richard Blout, *President.*

National Association of WIC Directors,
Jefferson City, MO, May 1, 1984.

Senator Jessie Helms,
Dirksen Senate Office Building,
Washington, DC.

Dear Senator Helms: We the undersigned State WIC Directors are writing as members of the National WIC Directors' Association to express our opposition to a number of provisions of S. 2545, to several of the Administration's legislative proposals regarding WIC, and to the proposal to allow states to convert WIC and child nutritional programs into a single block grant.

We are deeply concerned about many of the WIC changes proposed in S. 2545 because we believe they will weaken the program in several respects. In addition, we are troubled by Administration proposals that would cut funding levels as well as support for basic nutrition and administrative services provided by WIC. We also believe that placing WIC in a block grant with child nutrition programs could results in the dismantling of effective WIC programs and jeopardize the health of thousands of low income, nutritionally-at-risk mothers, infants and young children.

In March, the National WIC Directors' Association issued a statement of concerns that included ten legislative recommendations which are based on our years of experience in managing WIC programs at the state level. On April 9, these recommendations were presented to the Subcommittee on Nutrition of the Senate Agriculture Committee by Richard Blout, the Association president. We are dismayed to find that S. 2545 and the Administration's bill include not one of the Association's recommendations, and more disappointingly, include provisions that contradict a number of the Association's recommendations.

The provisions of S. 2545 and the Administration bill that contradict our recommendations include:

The provision of both S. 2545 and the Administration bill that reauthorizes WIC for only one year. We are particularly troubled by this. To be faced with one set of changes this year and another set next year would be highly disruptive. In some cases, it takes the greater part of one year to implement changes.

The Association recommends a four year reauthorization.

The proposed funding level in both S. 2545 and the Administration bill of only $1.254 in fiscal year 1985, $1.254 is $217 million less that what the Congressional Budget Office has estimated to be needed to serve the current caseload and would result in several hundred thousand participants being dropped from the program. Because WIC is currently serving only 3 million of the more than 10 million potentially eligible, we believe the authorization ceilings should be increased to enable the Appropriations Committees to consider funding that would allow more in the eligible population to be reached.

The association recommends program growth.

A reduction in administrative funds to 17% in S. 2545 and to 19% in the Administration proposal. We would emphasize that these funds cover the costs of nutrition assessments and nutrition education (which are an integral part of the WIC program), costs for printing food vouchers and monitoring and investigating retail stores to protect the program's integrity (tasks which are carried out by USDA rather than by the states in the food stamp program), and other basic activities to operate the program while guarding against waste and abuse. We do not believe we can continue to administer the program properly, provide needed nutrition services, and safeguard the program's integrity if administrative funding is reduced below 20 percent.

We also oppose the provisions in S. 2545 which would effectively abolish the procedures designed by USDA for allocation of administrative funds among states—procedures that currently allow some states to receive larger shares of administrative funds than 20 percent, so long as the total amount of administrative funds distributed remains at 20 percent. By effectively repealing these USDA procedures, S. 2545 ignores factors such as economies of scale and higher administrative costs in rural areas and would adversely affect states who need more administrative funds to operate their programs. Similarly, we oppose the provisions of S. 2545 that removes the Secretary's flexibility to meet critical, unforeseen needs in the administrative cost area when reallocating funds.

The association recommends that funding for administration be no less than 20 percent.

A provision of S.2545 authorizing the Secretary to establish a minimum participation level for state WIC agencies and to terminate smaller state agencies that do not meet this level. We urge that no minimum be established because this would eliminate some of the 31 Indian State agencies. We believe this provision violates the accepted practice of many federal programs of allowing Indian tribes to administer programs for their communities.

The association recommends that no minimum participation level be established.

A provision of S. 2545 allowing states to keep unspent funds that do not exceed 1 percent of a states's annual grant. This provision does not meet our concern that, in order for states to utilize fully their WIC grants (as the Appropriations Committees have repeatedly directed us to do), states need the authority to spend up to 105% of their food grant for a fiscal year, with expenditures exceeding 100 percent of the grant being subtracted from the state's grant for the following year.

The National WIC Directors' Association has strongly recommended such an approach based on program experience. Due to many uncontrollable variables, it is not difficult for a state to utilize 100 percent of its grant without risking overspending during the last 30-60 days of the year. Because states cannot know, until after the fiscal year is over, the exact cost of the WIC foods distributed in the final months of the fiscal year, most states are now forced to underspend their food grants in order to leave a margin of safety. The result is that some funds provided by the Congress remain unused at the end of each year while nutritionally-at-risk persons go unserved. Allowing states to spend up to 105 percent of their grants will help ensure that each state spends closer to 100 percent of its grant by protecting states—at no *additional federal cost*—if we overspend by a few percentage points.

The provision of S. 2545 does not address this need, and we strongly prefer the Association's recommended approach.

The association recommends that states be allowed to spend up to 105 percent of the food grant for a fiscal year with expenditures exceeding 100 percent being subtracted from the next year's grant.

In addition to these provisions of S. 2545 and the Administration bill that are in conflict with the Association's recommendations, there are a number of other provisions of S. 2545 that we also urge be rejected. These include:

The requirement that 50 percent of all funds be allocated to states serving the highest priorities. This would require dropping the carefully designed funding formula that USDA adopted just last year after extensive study and consultation with the states. We believe the current formula properly addresses priorities and that the law should not repeal USDA's formula and replace it with a new and untested statutory prescription that could mean a loss of funds and program cutbacks in a number of states. We believe that this area is adequately handled by the Department through the regulatory process.

The termination from WIC of infants and children who participate in the Child Care Food Program (CCFP). As the state and local administrators who testified on this issue explained to the Committee, local WIC agencies already tailor WIC food packages for infants and children in CCFP by reducing the amount of WIC foods these children are provided. This is the proper approach. Termination of these children from WIC is not. Since some children in CCFP get as few as five meals a week, and since CCFP lacks both WIC's link to health care and WIC's nutrition education component, eliminating these infants and children from WIC even though they are at nutritional risk would be most unwise from the standpoint of safeguarding these children's health.

The elimination of outreach and start-up costs as allowable administrative costs. The purpose of "outreach" in the WIC program—which includes the provision of information to doctors, hospitals, and social service agencies so they can refer persons most in need to WIC—is to help ensure that we reach the persons in greatest need at the earliest possible point in time. Since WIC is not an open-ended entitlement, outreach does not increase federal costs—rather, it improves program targeting. In addition, start-up costs—which refer to the costs of preparing to open a WIC clinic in a previously unserved area—are essential if WIC is to continue to reach rural areas that now lack the program. Failure to devote adequate resources during the "start-up" phase can lead to error and inefficiency that is more expensive to correct in the long run. There is simply no reason to deny states the authority to utilize some of their administrative funds for these functions.

The requirement that social security numbers be collected for all family members, including children and new-born infants, and that states conduct wage matches with these numbers. While these requirements may be appropriate in an entitlement program like food stamps, they are not appropriate in WIC. We are especially opposed to requiring women who have just given birth to make a trip to the Social Security office to apply for a social security number for a newborn infant. We would note that the majority of the participants in WIC are infants or children under 5—persons who, in many cases, do not now have social security numbers (and who, in all cases, have no earnings, either). The school lunch program does not require collection of social security numbers for infants and children, nor does it require wage matches. Such requirements are even more inappropriate in WIC, a program that has been far freer of abuse than any other food aid program. We strongly urge retention of current requirements which give us both authority and flexibility to determine when and what to verify—and what methods to use to conduct these verifications.

The requirements that WIC benefits for a participant's first month be pro-rated from the precise date the participant initially applies for benefits. Again, this may be appropriate in food stamps—but not in WIC. We cannot give someone exactly 17/30 of a WIC food package—we cannot divide egg cartons, quarts of milk, or cans of formula into fractions. What we can do is make appropriate and reasonable reductions in the food package when it covers less than a month. This is something that we, as responsible state officials, are already doing.

The requirement that states set up procedures to recover from participants, in cash, the value of any excess WIC foods prescribed. We are concerned that, in some cases, such as when the value of the additional food provided is small, it may cost more than it saves to recover these funds. In other cases in which an indigent mother may have received additional food through no fraudulent or purposeful effort on her part, recovery in cash may cause hardship for her and her family.

The requirement that no WIC program may operate in areas in which a Commodity Supplemental Food Program (CSFP) is operating. This would require the termination in a number of areas of either WIC or CSFP programs that now serve thousands of needy women, infants, and children. Current law requires that in all areas in which both programs are operated, systems must be established to insure that there is no dual participation. The systems have been in place, and there is no reason to close down WIC or CSFP programs and risk leaving thousands of mothers and children without nutrition services.

Finally, there are a few additional points we would like to make with regard to S. 2545. We are troubled by the provision of S. 2545 that deletes a current statutory requirement that poor mothers and children from migrant farmworker families receive continuous service to the maximum extent feasible as their families move from state to state. Data from the Public Health Service show that migrant mothers and children are among those with the highest incidence of a number of health problems that are associated with adverse pregnancy outcomes. We believe there is not a sound basis for changing the law here.

We are also concerned by another provision of S. 2545 that deletes a statutory requirement that funds withheld from a state due to an administrative deficiency on the state's part be restored if the state corrects the deficiency promptly.

In addition, we are concerned by the provision of S. 2545 and the Administration bill that drops the requirement for ⅙ of administrative funds to be used for nutrition education. Nutrition education is an integral and valuable part of the WIC program, and we believe the "⅙ requirement" is appropriate. What is needed is a reduction in some of the paperwork and documentation requirements USDA has imposed in connection with the requirement rather than the removal of the requirement, itself.

BLOCK GRANT PROPOSAL

Last but not least, we would like to express our very strong opposition to the proposal that we understand will be offered to authorize WIC and child nutrition programs to be merged into a block grant. We believe it is essential for WIC to remain an independent program if it is to have maximum effectiveness.

During the past several years, many of us have stated our opposition to folding WIC into the Material and Child Health block grant. We are equally opposed to placing WIC and the child nutrition programs into a block grant. If this were done, WIC would be put into competition for funds with programs operated by school districts and education departments—and we believe there is serious risk that the result could be reduced funding for WIC. We are also concerned that since no other programs in the proposed block grant are run in conjunction with health clinics or health departments, the health focus of WIC—which is unique among the food assistance programs—could be diminished. We urge that block grant proposals be rejected.

Thank you for your consideration of our recommendations and comments on S. 2545, the Administration proposals, and the block grant proposal. We believe the saying, "if it's not broken, don't fix it," is releveant to WIC. The WIC program is a success. It is improving the health and nutritional status of low income women, infants, and children across the nation. Any short-term fiscal savings achieved as a result of the provisons of S. 2545 or the Administration's proposals would have adverse consequences—both from a fiscal standpoint and from the standpoint of public health—in the intermediate and longer term. Let us not deny to tomorrow's generation the opportunity to develop to its full physical and mental capacity.

Sincerely,

C. Richard Blount,
President, Missouri WIC Director.

James Richard, Alabama WIC Director, Edith Sidle, Alaska WIC Director, Lynn Tso, Arizona WIC Director, Linda Christensen, WIC Director, Navajo Nation, Arizona, Barbara Blessing, Arkansas WIC Director.

Jack Metz, California WIC Director, Bill Eden, Colorado WIC Director, Laura Hammond, WIC Director, Ute Mountain Community Action, Colorado, Phil Reeves, Florida WIC Director, Margaret Park, Georgia WIC Director.

Helen Matsunaka, Hawaii WIC Director Joyce Sager, Idaho WIC Director, Gerri Seifert Indiana WIC Director, Laura Sands Iowa Nutrition Director, Sara Bonam, Kansas Director of the Office of Nutrition and Health, Peggy Kidd, Kentucky WIC Director, Dr. Rose Ann Langham, Louisiana Administrator of Nutrition Services, Linda Schumacher, Maine WIC Director.

Nancy Newell, WIC Director, Indian Township, Maine, Nancy Loring, WIC Director, Penobscot Indian Nation, Maine, Steve Trageser Maryland WIC Director, Kathleen DesMaisons, Massachusetts WIC Director, Doug Paterson, Michigan WIC Director, Pati Maier, Minnesota WIC Director, John Barr, Mississippi WIC Director, Dr. Jim Cox, Director, Choctaw Health Director, Jesse Thomas, Director, Community Health Services, Mississippi Band of Choctaw Indians.

David Thomas, Montana WIC Director, Lois Princ, Nebraska WIC Director, Carmene Tyndall, WIC Director, Nebraska Indian Inter-Tribal Development Corporation, Martin Brown Nevada WIC Director, Beverly Harder, WIC Director, Inter-Tribal Council of Nevada, Robin McBrearty, New Hampshire WIC Director, Pat Cleveland, New Mexico WIC Director.

Vanessa Riley, WIC Director, ACL Hospital Board, Pueblo of Acoma, New Mexico, Betty Atencio, WIC Director, Eight Northern Indian Pueblos Council, New Mexico, Rama Ray, WIC Director, Five Sandoval Indian Pueblos, Inc., New Mexico, Vangel Martinez, WIC Director, Pueblo of Isleta, New Mexico, Mary Lucero, WIC Director, Pueblo of San Felipe, New Mexico, Mary Lovato, WIC Director, Santo Domingo Tribe, New Mexico, Marlene Hannahs, WIC Director, Pueblo of Zuni, New Mexico.

David Loux, New York WIC Director, Maxine Jimerson, WIC Director, Seneca Nation, New York, Joanne Tracy, North Dakota WIC Director, Irene Lawrence, WIC Director, Standing Rock Sioux Tribe, North Dakota, Rosalie Bird Bear, WIC Director, Three Affiliated Tribes, Fort Berthod Reservation, North Dakota, Dinah Williams, Ohio WIC Director, Carol Waldvogel Oklahoma WIC Director.

Mark Teeley, WIC Director, Cherokee Nation, Oklahoma, Jean Evans, WIC Director, Choctaw Nation of Oklahoma, Elizabeth Brady Dennis, WIC Director, Citizens Band Potowatomi Indians of Oklahoma, Paralee Allen, WIC Director, Tonkawa Tribe of Oklahoma, Marcella Ruckman, WIC Director, WCD Enterprises, Inc., Oklahoma, Betsy Clarke, Oregon WIC Director, Manuel Cordero Olivencia, Puerto Rico WIC Director.

Eva Lundy, Rhode Island WIC Director, Mary Ann Totman, South Carolina WIC Director, Karen Pearson, South Dakota WIC Director, Cynthia Red Dog, WIC Director, Ceyenne River Sioux Tribe, South Dakota, William Black Lance, WIC Director, Rosebud Sioux Tribe, South Dakota, Jane Baxter, Tennessee WIC Director, Cathy Litteer, Texas WIC Director.

Sheila Walsh-McDonald, Utah WIC Director, Joy Morrell, Vermont WIC Director, Paul Matthias, Virginia WIC Director, Loren Bell, Washington WIC Director, Charlies Dawkins, West Virginia WIC Director, Audrey Koehn, Wisconsin WIC Director, Terry Williams, Wyoming WIC Director, Gail Ross, WIC Director, Shoshone and Araphahoe Tribes, Wyoming.

All of the state WIC director whose names appear have endorsed this letter. Geography did not permit each of these directors to affix his or her signature, but they have each authorized their names to be listed here.

PREPARED STATEMENT OF JOHN H. WALKER, STATE DIRECTOR, CHILD NUTRITION PROGRAMS, STATE OF MISSISSIPPI

Mr. Chairman and Members of the House Subcommittee on Hunger, my name is John H. Walker, State Director, Child Nutritions Programs, State of Mississippi.

I appreciate the opportunity to appear before this very important Subcommittee to provide information that I feel will be of value in the Committee's deliberations and ultimate findings.

I come to speak today on behalf of the Child Nutrition Programs, specifically, the National School Lunch Program, School Breakfast Program, Food Distribution Program, Nutrition Education and Training Program, Child Care Food Program, and Summer Food Service Program, all administered by the State Department of Education, Division of Administration and Finance.

As long time School Administrator in Mississippi I can go back some thirty-five years, prior to the time that funds were provided in sufficient amounts to assure that every child would have the opportunity to eat a nutritionally balanced meal at lunch time. During the fifties and early sixties some schools were able to provide meals for a very small percentage to the students, even as low as only 10-15 percent being able to participate on a daily basis in some areas of the State. Under these circumstances the facilities for preparing and serving of meals were very limited and most facilities were "make shift" type situations with little sophisticated equipment.

As we look as the situation today in the State of Mississippi, we find a completely different situation in that most School Food Service facilities have been included in local and State financed building programs, this we find generally adequate facilities with some advanced food preparation equipment. This contributes to the effective high participation in which our schools, both Elementary and High Schools, serve more than 80 percent of all student in attendance on a given day. In November 1983, for example, 83 percent of the average daily attendance were served lunch, of which 65 percent were free; 7 percent were at reduced price and 28 percent were paid. In the Second Congressional District 84 percent were served free, 4 percent at reduced price and 12 percent paid. There is absolutely no way that these students could receive the nutritional meal that they were served without the financial support provided by the Federal Government. The monumental decision by this country provide meals at school based on family size and income made it possible for many children to eat a nutritionally balances meal while at school for the first time. There is no question in my mind what whatsoever that the National School Lunch

Program has contributed to the nutritional welfare of this State's populace to a very high degree.

As you know, the intent of the National School Lunch Act is to protect the welfare of the nation's youth. This, of course, means all youth, therefore, we can ill afford to reduce the support for any segment, including the paying child. The only reduction in participation in recent years has been the paid category and as you know, nutrition is no respector of persons.

Every Public School in Mississippi participates in the National School Lunch Program, therefore, evey child in public schools has the opportunity to participate in a nutrition based program. In addition, some 75 parochial schools participate thus affording very good coverage throughout the entire State.

The School Breakfast Program, even though more limited in scope than the National School Lunch Program serves a vital need. There are students in Mississippi that receive the only balanced meals while at school, therefore, the breakfast at school serves a unique purpose in making it possible for students to have breakfast that they may not have had, were it not for the School Breakfast Program. There are 123 School Breakfast Programs in the Second Congressional District of Mississippi. Mr. Chairman I am of the firm belief that breakfast makes a child more responsive, energetic and attentive.

We, in Mississippi, are very pleased that the Food Distribution Program serves multiple needs. It is basic to the sound operation of the School Lunch Program by providing excellent foods that are supportive nutritionally as well as financially.

Currently the Child Nutrition Office of the Department of Education distributes foods to schools, residential Child Care institutions, charitable institutions, correctional institutions, and Emergency Feeding Operations. It is estimated that $15,000,000 in dollar value will be distributed during fiscal year 1984. It is rewarding to realize that not only are donated foods contributing to the nutritional welfare of people but also having an impact on the State's economy in addition to being of direct value to the Nation's farming interest.

The Nutrition Education and Training Program, which has struggled for funding, has gotten a lot of mileage in Mississippi in that 102 schools, 18,060 children, 150 educators, 1,022 School Food Service personnel, 205 Child Care educators, and 160 Child Care Food Service personnel have received Nutrition Education or food service training and materials. A Resource Library has been established consisting of the latest films and materials in nutrition. The circulation rate in these materials is about 80 requests per month to all sections of the State. I believe that the N.E.T. Program has had a real impact on Nutrition Education because it has reached a relatively large number of educators and teachers in the State.

The Emergency Feeding operations (Jobs Bill) in Mississippi consists of 11 feeding sites with an estimated average daily participation of about 2,069 success of this program is basically dependent upon the unemployment situation and due to this situation in Mississippi, the program has met some needs.

The Child Care Food Program in Mississippi serves two segments of children, those involved in the Head Start Program and those involved in an non-profit, tax-exempt Child Care facility. The Child Care Food Program has the responsibility of providing nutritional meals to the 33,000 children enrolled with some 28,000 in average daily participation. Approximately 92% of those enrolled are needy. It would be very difficult, if not impossible, for many parents to work were it not for these Child Care agencies. It is our belief that if the 4–6 year old child can be taught and led to eat nutritionally adequate foods at an early age, it would be continued in schools and even into later life thus having an impact on the basic nutrition of Mississippi society. I have seen this program grow from three centers in the early seventies to some 600 centers currently. In the Second Congressional District of Mississippi alone, there are 25 sponsors of Child Care Program serving 10,130 children per day.

There is one aspect of the Child Care Food Program that is of considerable concern. This involves the Family Day Care Home which is very difficult to properly administer and monitor. It appears that this program could mushroom into such proportions that not only would administration be increasingly difficult but funding may be a continuing problem.

The Summer Food Service Program in Mississippi serves about 40,000 children in some 50 agencies throughout the State. Until recent legislation limited participation to public entities, it was a program almost impossible to administer, however, the last two years has seen improvement to the extent that the program is now a viable one which serves some children through the period when the School Lunch is not available.

In summary, I am firmly convinced that the Child Nutrition Programs in Mississippi are working with a high degree of efficiency. The dedication and spirit of local level operators along with a State Child Nutrition staff eager to serve participating agencies makes it possible for the programs to reach an excessively large number of people throughout the State.

Thank you very much for the opportunity to give testimony at this hearing. I will be happy to answer any questions that the members of the Committee may have.

STATE OF MISSISSIPPI CHILD NUTRITION PROGRAMS

[Comparison of Participation Data School Year 1981 through School Year 1984]

	1981	1982	1983	1984
Lunch:				
Free	44,177,449	39,478,782	41,594,205	41,982,342
Reduced	5,597,015	5,346,932	4,719,262	4,767,614
Paid	19,282,228	17,534,940	17,358,282	18,052,498
Total	69,056,692	62,360,654	63,671,749	[1] 64,802,454
ADP	387,959	350,341	357,706	[1] 381,190
Breakfast:				
Free	19,202,688	17,145,953	17,757,881	18,263,143
Reduced	1,386,405	1,042,268	879,397	958,308
Paid	1,836,928	1,255,800	1,121,885	1,236,546
Total	22,426,021	19,444,021	19,759,163	[1] 20,457,997
ADP	128,148	111,109	112,268	[1] 120,341

[1] Estimated:

PREPARED STATEMENT OF ALIX H. SANDERS, SUPERVISOR, LEFLORE COUNTY, MS

Ladies and Gentlemen: My name is Alix H. Sanders. I am a member of the Board of Supervisors of Leflore County, Mississippi. May I express my appreciation as a member of the county's governing board for your concern with hunger in this county.

The Board of Supervisors is the governing body at the county level in the State of Mississippi. It is composed of five (5) members. As constituted in Leflore County, this board is composed of two democrats, two independents, and one republican. It is composed of five (5) males, four (4) whites and one (1) black. As the central governing unit, the board of supervisors concerns itself with the management and operation in all aspects of county government. The chief responsibility of the individual supervisor is to maintain the rural roads outside of incorporated area. Through the budgetary process, the supervisors are intricately involved in most aspects of life in the county.

As a member of the board and as a life long resident of this county, I hope my statement will be useful to this committee in determining what more to do about hunger in Leflore County in 1984. Without reservations I can state that there is hunger in this county today. One has only to look in the right places to see it. The more difficult question is why does it exist. Currently numerous programs are administered in this county to eradicate hunger. Several come to mind immediately. We have the free lunch and breakfast program in our schools. We have food stamps, meals for the elderly, and other programs in the county which operate in the area of housing and health care. In summary, the programs address the needs of the young, elderly, and the needy. But the question arises how then can you have hunger when there are programs designed to meet these needs.

By way of example, recently I spoke with the Sheriff of this county concerning a woman who lives in my supervisory district. This woman lives on a farm where the owner for a number of years has requested that she remove herself and her children as she is no longer affiliated with his farming operation. This parent occupies a house for which she pay no rent in which there is no electricity and lives primarily on welfare subsistance and food stamps. When these resources run out before the end of the month or before the next issuance of food stamps, this mother of five is left to her own devices to provide for herself and her family. Those of us who are familiar with this complicated technological society often ask the question, "Why people we see in the grips of poverty and hunger don't do this or do that to alleviate their condition?" What we fail to observe and understand is that often times they are incapable of functioning within our society. Herein lies the greatest impediment to a hunger-free society, i.e., the inability of the targeted population to negotiate their way through a complicated society to the benefits to which they are entitled. In short, ignorance is the greatest enemy to a hunger-free society. In Leflore County, of the 41,000 plus residents who live here, more that 25% receive food stamps. In both our city and county schools, more than 75% of the average daily attendance participate in a free lunch or reduced lunch program. Many of our elderly citizens who depend solely upon the meals program would be without subsistence and would probably have nutritional deficiencies if it were not for that one meal a day. The hunger and deprived conditions which remain are the results of either insufficent funding or inability of the targeted population to qualify for the entitlement.

There are two pointers that I would like to make to this committee in the administration of these entitlement programs affecting the ability of people to have food and subsistence. The first is eliminate the red tape in the administration of these programs. We could feed half the population in this county on the cost of the paperwork required to administer the monthly food stamp program. Seconly, if you want to do something—cut the paperwork, increase the benefits and send a congressional committee to investigates jobs. Jobs are what we need and want in this area.

Prepared Statement of James S. Robbins III, M.D., Chief of Staff, Greenwood-Leflore Hospital

I was asked to speak to this Committee in my capacity as Chief of Staff of Greenwood-Leflore Hospital. This hospital is a full service general hospital with 230 beds and 25 bassinets. There are thirty-seven physicians on the active medical staff and these include all the physicians in active practice in Leflore County except for one. The physicians in our community see the full spectrum of patients in the community. All of them see Medicaid and charity patients as needed.

I am a urologist which means that I limit may practice to disorders of the urinary tract and the male genital system. My specialty limits somewhat my professional exposure to problems of hunger. The medical manifestations of malnutrition would ordinarily be seen by the primary care physicians especially the pediatricians and family practitioners. My testimony is based on conversations with the other members of the Medical Staff and on a review of the records of those patients discharged from the hospital with a diagnosis of "malnutrition" or of "failure to thrive."

Since October of 1983 there have been 8,755 patient discharged from the hospital. Of these, seven patients have one or the other of the diagnoses listed above. One patient was a 47 year old woman with terminal lung cancer and thus not germane to this testimony. Of the other six, three were children five months old or younger. The other three were quite elderly, aged 78, 80, and 85. The three children were malnourished, not because formula was unavailable in the home, but because of maternal neglect in two cases and because of milk protein intolerance in the other. One of the neglected children died but the other two did well in the hospital with proper feeding technique and were discharged with Social Service and Health Department nurse follow-up. There are generally 8 to 10 children per year seen with this problem, and I am told that they usually do well once the home situation is improved.

The three elderly patients had problems similar to those of the children. One was a nursing home resident who refused food because of senility. One was an elderly lady who broke her hip. When she went home after hospitalization with this injury she just was unable to make it alone anymore. She was rehospitalized until she became stronger. Upon her second discharge she did well. The last patient lived with his daughter and he said on admission that she just hadn't fed him. He was discharged to a nursing home.

The veteran primary care physicians in Greenwood tell me that 15 years ago hunger was real problem in the Delta. They state that they saw many children and many adults who were obviously malnourished especially in the winter. They saw young children with severe anemia and with edema secondary to lack of dietary protein. The infant mortality rate was much higher, and the childhood death rate was much higher due to diseases associated with malnutrition. These physicians state that they no longer see these diseases at all. The six hospitalized patients cited above are a small sample but they are illustrative of the problem which remains. Hunger to the degree that a medical condition—malnutrition—results is limited to the extremes of age and then is almost always the result of ignorance of neglect.

During the periods of very early childhood and advanced age the human body is quite fragile and improper nutrition can have severe effects. At other times the human body is wonderfully resilient machine. It runs on almost any fuel and relatively severe dietary abuse is required to produce disease.

The infants that the pediatricians see with nutritional problems are almost always the result of teenage pregnancies in the economically deprived population. Children born into stable families with both a mother and a father in the home almost never have trouble of this kind. It would seem that an effort to reduce the rate of teenage pregnancies and illegitimate births would be the most effective means of attacking this problem.

There also seems to be lack of basic nutritional knowledge which is particularly apparent in the economically deprived segment of the population. An effort in this direction may be helpful.

I am not telling this Committee that there is no hunger in Leflore County. I am confident, however, that hunger is no longer the problem is was several years ago. The severe diseases resulting from hunger-starvation really—are rarely seen and then only in the limited circumstances I have described.

Less severe disorders resulting from hunger may exist, but these disorders are subtle and have other causes as well. There is no data which would permit me to make a statement in this regard.

If your Committee would like to know whether these more subtle medical problems exist and whether they can be correlated with the diet of the affected individuals, I believe this data can be gathered. It will require a significant investigative effort, but the medical community stands ready to participate if you wish.

I was instructed by the hospital medical staff at our last meeting to tell you that we appreciate your interest in our community, and that we are anxious to help you in any way we can.

Prepared Statement of Dr. Aaron Shirley, Project Director, Jackson-Hinds Comprehensive Health Center

My name is Aaron Shirley. I am a practicing pediatrician and the project director of the Jackson-Hinds Comprehensive Health Center in Jackson, Mississippi. I also serve as chairman of the Board of Trustee of the Mississippi Medical and Surgical Association, an affiliate of the National Medical Association. I appreciate this opportunity to come before you to share my views on the problems of hunger and malnutrition in our nation. I am sure you are familiar with the Field Foundations Survey of Hunger in the United States in 1967 with a follow-up study ten years later. I had the opportunity to participate in these surveys and was also part of a team which visited this area in April and May of this year. My first hand experience with nutritional problems of the poor is not limited to the few weeks spent during these studies however. Mine is an everyday experience as we provide a wide range of health and health related services to more than 26,000 poor in the City of Jackson and surrounding rural Hinds County, including WIC certification and nutritional counseling to 5,000 poor pregnant women, infant and children.

In 1967 when we examined children in this very town and outlying rural communities we saw many children on the verge of actual starvation. They were stunted in their growth and development, dull and with very little vigar as you would expect of 3, 4, and 5 year old children. Ten years lated, and again in April and May of this years we found similar conditions but not to the extent to which they existed in 1967. It cannot be denied that the overriding factor contributing to the improvements which we did see has been due to the combined benefits of the various food assistance programs put into place during the past decade. This is not to say or to imply that poverty related hunger and malnutrition no longer exist. It does exist. It is still wide spread among the poor of our state, with children and the elderly being particularly affected. With the absolute number of individuals in poverty growing the problems are sure to deterioriate, and without appropriate intervention we may soon find ourselves back to the conditions of 1967 and the numbers adversely affected in this state would be high. For instance, there are 425,000 children participating in the school lunch program. Of these, 290,000 or 68 percent receive the meals free or at reduced price, meaning they are from families in poverty. When we consider that poor children obtain ⅓ or ½ of their daily nutrients from school lunch we can readily see the potential negative impact on those who may no longer be able to affort these meals due to cut backs and changes in eligibility requirements. Some might argue that the difference will be made up at home. This is just not the case. From our own first hand experience we find that 70 percent of the 5,000 individuals, mostly children, which we certify annually for the WIC Program have home dietary histories deficient in vitamins A and C. Forty-five percent (45 percent) are deficient in iron and 30 percent deficient in protein. In those children 3 to 5 years of age, fifteen percent (15 percent) are deficient in calcium. And as we interviewed family after family recently and looked in their refrigerators and on their pantry shelves toward months end we could easily determined the reason, not enough food!

Over the past months their appears to have developed a controversy over this issue of hunger and malnutrition in our country. It is my understanding that even your being here trying to sift out the facts has provoked some degree of resentment and suspicion on the part of local officials. I can tell you over the years this has been a predictable reaction of those who have consistantly ignored the problems of poor people and who have fought hard to retain a political and economic system which perpetuates poverty and all that living without an adequate income implies; poor housing, malnutrition, ill health and shortened life span. You will see some of this for yourself as you visit families in this area. I hope that you will keep in mind as you observe these families that the hunger that they speak of is not the occasional discomfort that you might experience on a busy day in which you might miss a lunch or some other meal. The hunger which you see here is ongoing and leads to chronic malnutrition, and the consequencies of this type malnutrition takes it's toll as pointed out in the attached publication from the March, 1983 Pediatric Annals, a professional medical journal.

Gentlemen, in closing, I ask that you give serious consideration to immediately increasing the amount of funds for the various nutrition support programs—all of them; food stamps, WIC, school breakfast and school lunch. I say increase them all because it is obvious to many of us that one meal, or even a portion of a meal can make the difference between a child who is healthy, happy and capable of learning and developing into a productive citizen or one who is hungry and malnourished, apathetic and vulnerable to sickness and disease and possibly a shortened life span.

[From Pediatric Annals, March 1983]

Nutrition, Infection and Immunity

By JOSE IGNACIO SANTOS, M.D., JOSE LUIS ARREDONDO, M.D.
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INTRODUCTION

Susceptibility to infectious disease is multifactorial and impinges on native and acquired immunity influenced by the host's genetic constitution, sex, age, and nutritional status.

The worldwide prevalence of malnutrition is difficult to ascertain; however, it is generally accepted that the coexistence of nutritional deficiency states and infection represents the leading cause of morbidity and mortality in pre industrialized countries and among the poorer populations of affluent countries. The report of the Inter-American Investigation of Mortality in Childhood provides the first in-depth series of data on deceased children, and documents causes.[1] The results of this and similar clinical, dietary, and environmental surveys indicate that for many countries in the Western Hemisphere infectious diseases represent the leading cause of childhood mortality and that malnutrition continues to be the most serious health problem.[2-4]

Clinical, metabolic and biochemical evidence, largely derived from these and similar human epidemiologic surveys as well as laboratory animal experiments, provides substantial support for the concept that malnutrition may affect host susceptibility to infection and the latter (once established) can result in further deterioration of the host's nutritional status.

Although patients with clinically apparent signs of malnutrition other than obesity are not commonly seen in health care facilities in the United States, physicians are becoming increasingly aware of the association of malnutrition with other disease states such as cancer, renal failure, liver disease, cystic fibrosis, and prematurity. It is also recognized that these patients, already debilitated by underlying acute or chronic illness, are further compromised by associated nutritional deficiencies and are at increased risk for severe, often fatal opportunistic infections. These observations have resulted in an increased interest in the interaction between nutrition and disease and more specifically in the role of nutritional support to improve the host defenses of seriously ill patients. Indeed, one of the most notable advances in medicine during this past decade has been the development and utilization of specialized diets and feeding techniques for patients who can not digest, absorb or take in adequate nutrition orally. While there is no doubt that we must refrain from unwarranted enthusiasm in prescribing nutritional support as a therapeutic adjunct, it is clear that the understanding of the interrelationships between nutrition, infection, and immune function is more than just another intellectual exercise. Information which has been gathered from epidemiologic surveys in developing countries should provide us with a better understanding of disease and a more rational approach in the treatment of nutritionally compromised infants and children with infections.

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INTERACTION OF NUTRITION AND INFECTION

Malnutrition represents a state in which there exists a deficiency and/or excess of one or more essential nutrients which may or may not be accompanied by overt clinical signs and/or loss of specific function. A malnourished individual would be, in the modern language, a nutritionally comprised host. While it has proved easier to define the effects of infection on nutritional status, it has been more difficult to determine the role of nutrition or specific nutrient deficiencies isolated from other environmental factors, on host susceptibility to infection. Further, the nutritional status of the host may have a profound effect on the outcome of specific infectious diseases. For example, the walling-off process initiated by an infecting agent requires the synthesis of fibrin polysaccarides and collagen. This process would be retarded with lack of essential precursors such as protein. In this situation, in which there is no walling-off, the infection may be expected to spread, increasing both the severity of the disease and the utilization of additional nutrients.

Some purpose may be served to illustrate this synergistic relationship between nutrition and infection, a combination which accounts for most of the morbidity in the world. Table 1 lists mortality figures for children under five years of age in 13 Latin American cities. The relationship of nutritional deficiency as associated cause of death to three broad grouping of underlying causes is clearly illustrated by these figures. Nutritional deficiency was associated cause in 47.1% of all deaths. A higher association, 60.9% is observed when the underlying cause of death to three broad groupings of underlying causes is accord with previous studies which indicate the synergistic action of infectious diseases and malnutrition.[4]

Diarrhea, measles and respiratory infections are of minor consequence in the well-nourished child but obviously deadly in the malnourished host, and the host attempting to meet the challenge imposed by the offending organism finds himself nutritionally bankrupt and unable to draw further from his depleted reserves of proteins, minerals and other essential nutrients; necessary components for a competent host response.

IMMUNOCOMPETENCE IN THE MALNOURISHED HOST

Having touched on the interactions between undernutrition and infection, let us examine briefly the manner by which malnutrition favors increased susceptibility to infection. It is well accepted that the malnourished host is more susceptible to infection. However, since studies of malnourished subjects have generally dealt with generalized malnutrition involving multiple deficiency states, it is difficult to attribute changes in the immune status to any specific nutrient deficiency. The most one is able to do is document the changes in the immune response and determine whether these changes are reversible with improved nutrient intake.

Several immunologic functions have been studied in children with varying degrees of malnutrition who are generally grouped in the literature into the category of protein-energy malnutrition, or protein-calorie malnutrition.

Protein-Calorie Malnutrition

Protein-calorie deficiency is generally considered to represent the most common nutritional problem in the world. Depending on the precise composition of the diet, protein-calorie deficiency results in three main clinical syndromes — marasmus, kwashiorkor or nutritional growth failure. Marasmus which denotes starvation, results from a deficiency in total calories and is clinically characterized by absence of subcutaneous fat and wasted muscle. In contrast, kwashiorkor is considered to result from consumption of a diet deficient in protein relative to calories and is characterized by wasted muscle and edema. It should be noted that the most important precipitating factor in the pathogenesis of the kwashiorkor state is an infection in the already semi-starved or marasmic child. Other clinical manifestations of this clinical entity include growth failure, hepatomegaly, hair changes and dermatoses. There is always hypoalbuminemia and a decrease in the total serum protein. Kwashiorkor has its main incidence during the second year of life or after weaning from the breast. Diets inadequate in total calories with a disproportionate lack of protein will result in either marasmus or kwashiorkor or in a mixed type, marasmic-kwashiorkor. In nutritional growth failure or dwarfing there are no clinical signs, only low weight corresponding to age. Table 2 exemplifies the classification utilized by the Food and Agriculture and World Health Organizations.[5]

Although severe forms of protein calorie malnutrition can be diagnosed clinically, nutritional assessment provides an objective characterization useful for the

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TABLE 1

NUTRITIONAL DEFICIENCY AS ASSOCIATED CAUSE OF DEATH UNDER FIVE YEARS OF AGE BY UNDERLYING CAUSE GROUP IN 13 LATIN AMERICAN PROJECTS COMBINED[1]

Underlying Cause Group	Total Deaths	Nutritional Deficiency as Associated Cause	
		Number	Percent
All Causes	21,951	10,349	47.1
Infective and Parasitic Diseases	12,598	7,667	60.9
Diarrheal Disease	8,770	5,331	60.8
Measles	2,103	1,311	62.3
Other	1,725	1,025	59.4
Nutritional Deficiency	1,163		
Diseases of Respiratory System	4,469	1,435	32.1
Other Causes	3,721	1,247	33.5

TABLE 2

SIMPLIFIED CLASSIFICATION OF PROTEIN-CALORIE MALNUTRITION[5]

Condition	Body Weight as Percent of Standard	Edema	Deficit in Weight for Height
Underweight Child	80 to 60	0	Minimal
Nutritional Dwarfing	<60	0	Minimal
Kwashiorkor	80 to 60	+	++
Marasmus	<60	0	++
Marasmic Kwashiorkor	<60	+	++

diagnosis and management of morbid and premorbid states. Anthropometric measurements including weight as percent of standard, deficit in height for weight, head circumference, triceps skinfold-thickness, arm muscle circumference and age, when compared to a recognized standard have been useful to identify moderate and severe malnutrition. Once existence of this condition is suspected, a biochemical profile including the measurement of serum albumin, transferrin and the creatinine height index provides the objective information. Cell mediated immunity can also serve as an index of protein undernutrition. Assessment should include total lymphocyte count and delayed type hypersensitivity response to common skin test antigens such as mumps and candida.

Mucosal Immunity

The first barrier to an infectious agent is provided by the physical integrity of the skin and mucous membranes. The submucosa of the gastrointestinal and respiratory tracts contains plasma cells which synthesize IgA. Deficiency states which lead to functional and structural changes in epithelial lining of the respiratory and gastrointestinal tracts appear to exert the greatest influence. Deficiencies in protein, vitamin A, B complex, ascorbic acid, and zinc are frequently associated with tissue changes that lower resistance.

Cell Mediated Immunity

The thymus gland is an important regulator of cell mediated immunity. Thymic involution normally occurs with advancing age but can be precipitated by severe stress related to any number of disease states including malnutrition. Prominent atrophy of the thymolymphatic system of severely malnourished children and adults has been documented histopathologically in autopsy studies and functionally in clinical studies of cell mediated immunity.[6-8] Additionally, the organ weight of tonsils, lymph nodes and spleens have been reported to be significantly reduced when compared to those of normal children.[9] Clinical observations have also reported a decrease in the number of circulating T-lymphocytes and depressed T-cell function as determined by delayed skin test reactivity and in vitro assessment of cellular proliferative response.[10-12] Delayed hypersensitivity skin tests have been negative or markedly reduced in malnourished children and their lymphocytes show decreased blast cell transformation and decreased incorporation of thymidine into DNA in the presence of specific mitogens.[9,11,12] Clinically malnourished individuals are more susceptible to opportunistic infections, gram negative septicemia and disseminated herpes virus infections. They also have a tendency to develop gangrene rather than suppuration and their infections tend to run a more severe course.[14-15] Thus, studies of T-cell function coupled with clinical observations of increased susceptibility to intracellular and viral infections support the thesis of depressed cell mediated immunity in the malnourished host.

Humoral Immunity

Malnutrition affects the humoral immune system in diverse fashion. The B-lymphocytes when activated by antigens differentiate into immunoglobulin secreting cells. Several studies have shown that in malnourished subjects, B-cell subpopulations, immunoglobulin synthesis and metabolism are normal and that immunoglobulin levels are not usually depressed and are often elevated.[16-18] Studies on specific serum antibody responses to several antigens have been made in malnourished individuals with varying results.[19] However, few of these studies have carefully defined or standardized the antigens used, comparisons have included subjects of different ages and nutritional status making it difficult to interpret the observed variations. In marked contrast to normal or raised levels of circulating immunoglobulins, secretory immunoglobulin (IgA) levels in the respiratory and gastrointestinal fluids of malnourished children are generally decreased as is their secretory response.[18,20] It is reasonable to conclude that impaired mucosal immunity both as a result of changes in the integument and reduced secretory antibody response may explain in part the frequency and severity of gastrointestinal and respiratory infections in malnourished children.

Complement System

Complement levels appear to be somewhat diminished in malnourished subjects. Studies of serum complement indicate low levels of hemolytic complement activity but varying levels of the complement component C_3.[21,22] Similarly, reports on the chemotactic and opsonic activity of the serum of malnourished children are conflicting, making it difficult to draw conclusions.

Phagocytic Activity

Many recent studies have investigated the production, mobilization and the bactericidal activity of phagocytic cells. Because of the difficulty in harvesting adequate numbers of monocytes and macrophages, most studies have focused on the polymorphonuclear leukocyte.

Total leukocyte count in malnutrition is usually increased or normal. Functional studies indicate impaired chemotaxis in malnourished children with and without overt evidence of infection.[18,23] Several studies have also indicated impaired in vitro microbicidal activity, increased resting metabolism and decreased iodination by polymorphonuclear leukocytes of infected malnourished children.[24,25] While the myeloperoxidase bactericidal mechanism appears to be diminished in proportion to the impaired microbiocidal activity, concentration of enzymes themselves have been reported to be normal.[26] It appears that while there is a defect in the leukocyte inflammatory response of malnourished children as evidenced by depressed chemotactic activity, phagocytosis is normal.

Thus, available data suggest that aggregate nutritional deficits can be expected to reduce the host's ability to cope with exposure to an infectious agent by altering various components of the immune response. It has been only in recent times that we have begun to understand the very important intermediary role that the immune system plays in the interaction, malnutrition-immunocompetency-infectious disease. We now appreciate that any compromise in what might be considered optimal nutritional state may affect immune function and would be expected to reduce the host's ability to cope with exposure to an infectious agent.

NUTRITIONAL CONSEQUENCES OF INFECTION

Infections are accompanied by general and specific symptoms as well as by a sequence of hormonal, metabolic and immunologic responses, all of which have a nutritional cost. The responses to infection may result from a combination of functional and structural alterations of body constituents caused directly by the infectious agent or as a consequence of the host response to the infectious process. In general terms, the outcome of infection may be influenced by decreased food intake, increased requirements, absolute losses and functional wastage in the form of nutrient redistribution and sequestration.

An individual's response to infection is a function of immunological and nutritional status as well as of the type and severity of the insult. The most important factors contributing to the effect of infection on the intake and efficiency of use of food by children include increased losses as a consequence of diarrhea and reduced intake through food withdrawal and anorexia. Anorexia and fever are important physiological responses mediating the effects of infections on nutrition. The anorexia that accompanies infection, although difficult to quantify, results in decreased food intake.[27] Similarly, if an infection is accompanied by fever, the associated hypermetabolic events result in an increased caloric expenditure.[28] There are often physical reasons for decreasing food intake such as a sore mouth in herpetic stomatitis, cancrum oris of measles, altered mental status in the patient with encephalitis or a child who is ventilator dependent because of necrotizing pneumonia.

The nutritional cost of infection or recurrent mild infections in a well nourished child may not be associated with clinical overt manifestations or loss of specific function. In the marginally nourished child, the child with chronic illness, or in settings where the prevailing diet is barely sufficient to sustain normal growth, recurrent bouts of infection will precipitate or aggravate protein calorie malnutrition and can result in impaired growth, particularly in its linear expression. The relationship between frequency of infection and growth and development is illustrated in Figure 1. During the first six months while still being breast fed, the infant who is born perhaps weighing less than his expected potential because of maternal under-nutrition, does quite well and is actually able to surpass the median weight for age standard. However, coincident with being weaned from the breast, and being introduced to a gruel, or milk formula diet prepared in water from a non-potable source, the child experiences recurrent and prolonged bouts of diarrhea and other infectious illnesses. The nutritional wastage and metabolic cost associated with these recurrent infections results in net energy deficiency which culminates in growth failure so that by three years of age his body weight is under 60% of the reference standard.[25]

Other consequences of infection include nutrient redistribution and sequestration. During infectious illness most intracellular minerals undergo functional sequestration within body pools or depots. For example, the concentrations of iron and zinc in the serum generally decrease and the concentration of copper generally increases.[10-12]

In general it has been found that in many infectious diseases, the serum iron level drops significantly usually before there are other signs of infection such as fever. The iron is not lost from the body but is sequestered in the liver, reticuloendothelial system and bone marrow. While this does not represent an absolute loss, this sequestration does represent a functional wastage as the nutrient is essentially nonavailable for its normal metabolic or physiologic purposes. It has been suggested by Weinberg[13] and others that the decrease in serum iron might reduce the growth of pathogenic microorganisms. In fact, many studies have shown that certain species of bacteria grow poorly in medium containing low concentrations of iron and that iron supplements increase the growth of bacteria in vitro and in vivo.[14,15]

In contrast to the hypoferremia observed with the majority of infectious illnesses, hyperferremia has been reported during bacillary dysentery, typhoid, and acute hepatitis.[11,16] Similar changes in zinc concentrations also occur. Zinc plasma levels also increase and their role in wound healing has been postulated as an aid in the development of immunity.[17] In contrast, serum copper rises in proportion to the synthesis and release of copper-carrying protein, ceruloplasmin. A possible role for the increase in plasma copper in the form of ceruloplasmin may be in regulating catecholamine levels and serotonin.[17]

The most important nutritional consequence of infection is negative nitrogen balance. An initial decrease in the plasma concentration of amino acids is followed by an increased breakdown of body protein resulting in an increased synthesis of urea. The concomitant breakdown and increase in protein synthesis can be related to the host's immune response. Every host defense mechanism from phagocytes to acute phase proteins is ultimately dependent upon the synthesis of specific key proteins in sufficient quantity.

Infectious illness causes the host to undergo a large number of very acute metabolic responses. As depicted in Figure 2, these responses contribute to the loss of nutrients either through absolute wastage or increased utilization for body defense to keep the host alive. The impact will obviously be greater in the nutritionally compromised host.[18]

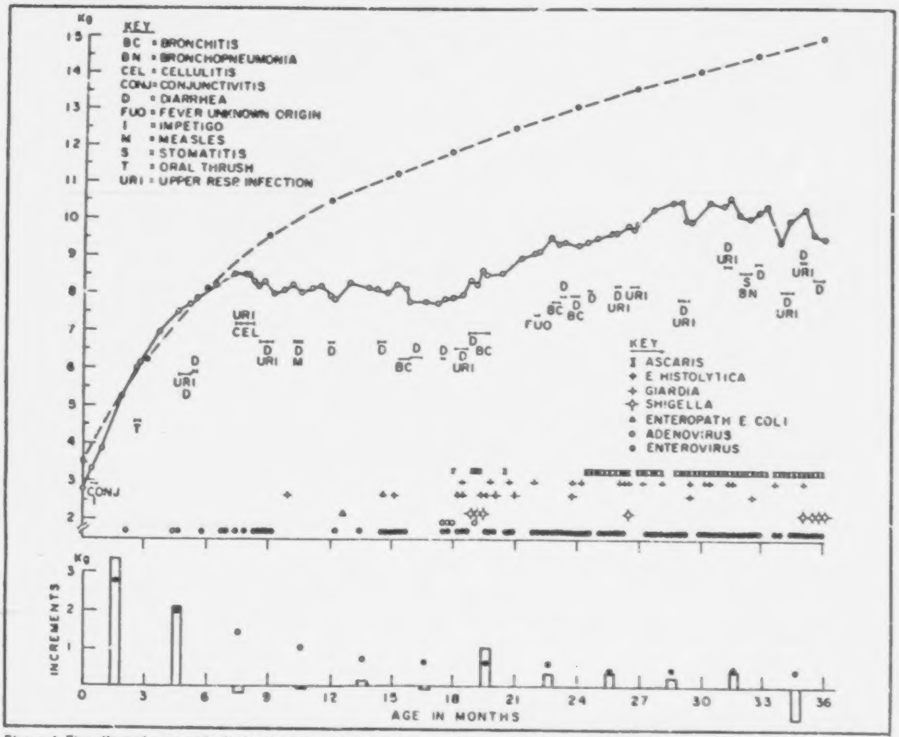

Figure 1. The effect of repeated infections on the nutritional status and growth of a male infant in first three years of life. Solid line is the weight of the child, broken line represents median of reference standard. Length of each horizontal line indicates duration of infection. Each mark represents a week positive for specific infectious agent. Bottom: Observed weight gain (vertical bars) versus median increments of the standard (solid circles). (From Mata et al.,[14] with permission)

From a nutritional point of view, this process of nutrient loss and redistribution has the potential for being exploited to the benefit of the host. By either selectively replacing nutrients being rapidly metabolized which are essential to optimal immune fuction and or by withdrawing nutrients that the parasite or invading organism needs, we may be able to improve the host response to infection.

SUMMARY

The triad of malnutrition-infection-immunity describes a phenomenon well recognized but not completely understood. An infectious disease, depending upon type and severity will have a varying effect on nutrient metabolism which will be modulated to a great extent by the host's underlying nutritional status. Nutritional factors play a significant role in resistance to infection and almost any nutritional deficiency adversely affects one or more components of the immune system. For example, specific nutrients may be more essential for the multiplication of pathogenic organisms than for the maintenance of the host.

The future may see situations where withholding specific nutrients from the host's diet we might be able to influence favorably the outcome of specific disease.

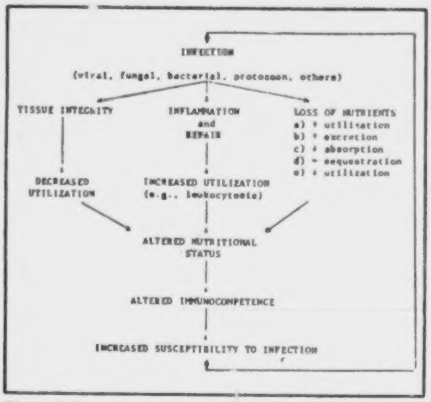

Figure 2. Possible pathways by which an infectious agent may alter nutritional status which in turn can impinge on immunocompetence leading to a viscious cycle involving the triad, nutrition-infection-immunocompentence (Adapted from Santos and Vitale[38]).

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Situations may also arise in which dietary modulation of specific host defense mechanisms may be used selectively to the advantage of the infected individual. Obviously we are at the frontiers of our understanding of the complex interactions among nutrients, immunocompetency and infection.

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PREPARED STATEMENT OF AGNES HINTON, R.D., M.S., DIRECTOR, NUTRITION SERVICES, MISSISSIPPI STATE DEPARTMENT OF HEALTH

Good afternoon. I am Agnes Hinton, R.D., M.S., Director of Nutrition Services for the Mississippi State Department of Health. I techically supervise 4 other nutritionists at the state level, 9 district nutritionists, and 68 FTE local nutritionists. 11 of those local nutritionists are funded by our department but work in independent health agencies.

Unlike many state health agencies the MSDH provides direct health services for our citizens, including the areas of maternity, family planning, infant and child health, chronic disease, and communicable disease through health departments located in each of our counties with larger counties providing multiple sites. Nutrition counseling by nutritionists, nurse practitioners, nurses and physicians is an important component of many public health programs and is an essential part of any medical service in order to ensure appropriate outcome. The Department's involvement with direct food assistance is mainly through the WIC program, referrals of patients for programs such as Food Stamps or Community Action Agencies, and food protection at public feeding sites.

This year all the states in this region were asked to provide information to our regional HHS office regarding pockets of hunger. Our efforts to compile this information were directed through state, district, and local level physicians, nutritionists, social workers, nurse practitioners and nurses. We found little concrete comprehensive data on which to base estimates of need, although there were certainly individual reports of hungry people, as well as reports from social service agencies of increated need for food assistance. Waiting lists for services were noted in a number of congregate and home delivered meal programs for elderly. Transportation to access available services is clearly a problem a problem in many areas of the state. Special needs, such as elderly on sodium restricted or diabetic diets, may prevent individuals from receiving assistance from current programs. The greatest needs in many areas, including the Delta, appear to occur in the elderly population. While we felt that our information was inadequate to give a comprehensive assessment of the situation. Our general consensus was that many people are better nourished than they were previously, but this was largely due to federal food assistance programs such as WIC, Food Stamps, and Child Nutrition Programs. Many of our citizens live a marginal day-to-day existence dependent mainly of public assistance, food stamps, food pantries or congregate feeding sites and programs such as WIC for their food intake. I would like to emphasize the absolute necessity that these programs be maintained and in some instances expanded or modified to better meet these critical human needs.

You've heard Mr. Barr describe our WIC program. We have found WIC to be an important adjunct to health services, and feel its effectiveness has been largely due to its integration into our agency's health care. One of the main strengths of WIC is the provision of nutrition assessment and education along with food supplements tailored for the individual patient. Changes in attitude, food habits, and food purchasing resulting from the nutrition education may affect the entire family's health for many years. We need to expand this focus on nutrition education to other food assistance programs, such as Food Stamps. I am pleased to see such a component for food stamps included in H.R. 5151, the Hunger Relief Act of 1984.

While we do feel that WIC is an effective program, it is not a panacea for all the people who need food assistance in Mississippi. WIC is limited to specific target groups and is a food supplement only. Transportation barriers prevent some eligible participants from fully participating in the program. Program restrictions, such as the limit of 8 pounds of special formula per month, prevent the special needs of some participants from being fully met. Our specific recommendations for this committee:

(1) We would like to continued strong funding for WIC.

(2) We need to remember that WIC is complementary to Maternal and Child Health Programs. The Health programs founded through the MCH Block Grant and through Community Health Centers provide the critical health services, without which WIC would be greatly diminished in its impact. Funding for these programs needs to be supported as well as funding for WIC.

(3) We need to expand nutrition education efforts in food assistance programs, such as Food Stamps, and we need continued emphasis on nutrition education as an integral part of WIC. We support HR 5151, the Hunger Relief Act of 1984, and hope that the nutrition education portion for Food Stamps will not be further diluted.

(4) Some changes in WIC regulations such as allowing more special formula for infants, would allow us to better meet special needs.

(5) Elderly feeding programs need increased funding to meet the needs of our senior citizens. To ensure that the dollars are spent wisely, professional dietetic consulations at the state level should be required.

(6) Finally, we need appropriate and timely data regarding the nutritional status of our population. HR 4684, the National Nutrition Monitoring and Related Research Program would help provide such data. The Association of State and Territorial Public Health Nutrition Directors, in which I represent Mississippi has this past week presented testimony in support of this legislation, with some recommendations for minor changes which would strengthen the Act. I have attached a draft copy of our testimony. The fact that the nutrition monitoring portions of HR 5151 have been dropped make the passage of this Act vital. It is time to implement such a system, so that we can more accurately know the level of nutritional problems which exist in our population and what impact food assistance programs have.

(7) Support for nutrition training should again be included in the National Health Services Corps, and service in rural health department clinics should be an option for pay-back of support. While WIC has allowed us to establish nutrition positions, it has been very difficult to fill these in rural areas such as this district.

I appreciate the opportunity to testify before this august group. I hope there will be specific outcomes which you can help bring about, so that in 1985 there will be no need for a hearing of this sort.

TESTIMONY OF DR. JERIANNE HEIMENDINGER, REPRESENTING A COALITION SUPPORTING H.R. 4684, WASHINGTON, DC, JUNE 20, 1984

Mr. MacKay, Mr. Brown, Mr. Walgren, members of the Committees, and Associates: It is a pleasure to be here today to speak to you on behalf of colleagues in Government, Health and Service Organizations who share a common concern for nutrition status monitoring, related research and the practical uses to which these data and methods are put.

In recent years expanding scientific knowledge about the relationship of dietary constituents to chronic disease, aging and even metal health has added impetus to the earlier attention paid to monitoring problems of undernutrition. There is a steadily increasing interest in improving specific dietary practices related to prevalent health problems among virtually all population segments—pregnant women, growing infants and children, adolescents, adults in the middle years, older adults, and ethnic or low income subgroups. Increasingly, correction of nutrient deficiencies seen most ofter and most harmfully among the poor is viewed as but the first step toward the goal of an optimal diet which not only prevents or delays onset of major chronic diseases but also supports optimal physical and mental performance.

Setting priorities for nutrition programming, research and epidemiologic studies has for many years been the domain of the Federal Government. To this task they have applied strong leadership and scientific integrity; the success fo this strategy is self-evident. But the 1980's are a time of transition in which three major trends have occurred.

First, there has been a shift away from establishing priorities nationally toward giving flexibility and responsibility to the States who, in turn, may pass this on to localities or call upon the private sector to help.

Second, there has been a slowing of growth in health and food assistance programs and increased emphasis on fiscal accountability and effectiveness evaluation.

Third, we have experienced increased demands for public services, stiffer competition for available resources, and re-direction of existing monies rather than allocation of new monies to meet new priorities.

These trends have exponentially increased the need on non-Federal agencies and organizations for current and accuarate data upon which to make rational decissions about health, nutrition and food programs which they operate or are considering. They have an acute need, therefore, for data relevent to their own jurisdiction which answer such key questions as:

1. Which subpopulations and geographic areas are at greatest risk for poor health status?
2. What interventions are being offered to address those health risks?
3. Are the populations at risk receiving the interventions they require?
4. Are the interventions effective in improving the health status of the target populations? [1]

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[1] Peoples, M.D. and C.A. Miller."*Monitoring and Assessment in Maternal and Child Health: Recommendations for Action at the State Level", paper presented at the conference, "State Action to Improve Child Health," Washington, DC, May, 5–7, 1982.*

Lacking the funds to finance their own surveys, more and more agencies study Federal research reports such as the health and nutrition examination survey or the food consumption survey for answers. But the answers to many very practical questions elude most users. For example, Federal survey findings are not related with health criteria to provide reports of prevalence of obesity, anemia, elevated serum cholesterol levels, or conformity with dietary recommendations such as the U.S. recommended dietary allowances. To do this properly requires intimate understanding of the statistical design of the studies, which many users lack, and therefore results in a multiplicity of misinterpretation.

The data tapes can be used to create synthetic estimates for sub-national jurisdictions, but variables such as age, income and ethnicity needed for program targeting are inadequate for many users, and often the statistical and computer resources needed to develop customized reports are not available.

Certain data are not collected. These include statistics linking persons with problems with the services they receive and subsequent change in problem status.

There is little practically oriented epidemiologic research to develop shorter and cheaper methods of monitoring nutritional status, food consumption, nutrition knowledge, and socioecomonic characteristics suitable for use by states, localities and others needing such methods. Hunger is a specific example. Methods are needed to determine the magitude and severity of the problem, but at least 15 States are struggling independently with the problem.

H.R. 4684 comes at a time of acute need. We believe that, with the changes suggested below, H.R. 4684 could result in a stronger and more participatory relationship with the Federal Government that allows each of us to do our own job better and thereby better meet the country's nutritional needs.

Turning to the language of H.R. 4684, our perspective on its provisions and our recommendations for change follow in order of the legislation:

Section 101. A coordinated program and the directorate. We believe that a ten-year plan as developed and implemented by the three-agency directorate will be a vehicle through which to address the needs outlined above. Such a directorate would create a focal point for planning surveys, setting research priorities, and drafting reports that is accessible and responsive to parties outside the Federal Government.

With its expertise in determining nutritional status of troops, nutritional influences of stress, and the nutritional well-being of American allies, the involvement of the Secretary of Defense as a chairperson is quite appropriate. We also believe that inclusion of advisory council members on the directorate strengthens communications with the non-Federal sector and will hasten progress toward meeting common objectives.

The only changes we suggest are the addition of a community services administration representative to better include the needs of low income persons and removal of the requirement that the members from the advisory council be designated as the chairperson and vice-chairperson. We believe that these liaison members could be selected by the advisory council itself.

Section 102. Functions of the directorate. With regard to (a)(1), goals of the coordinated program, we would like to emphasize the provison of technical assistance, training and consultation to States and localities by including specific language to this effect.

With regard to (a)(4), the National Science Foundation Competitive grants program, we would like to assure the utility for this research to State and local users by including language that the competitive grants process would require applicants to involve States and localities in the grant application and subsequent implementation.

With regard to the entirety of section 102, we feel it is imperative to add another program of competitive grants for States and localities complementary to the research program grants to be awarded to universities through the National Science Foundation. This program would encourage and assist them in the conduct of monitoring and surveilance of nutrutional status, food consumption, nutrition knowledge, service characteristics and utilization by special populations or by the population as a whole. It would include surveillance of problems of low income people pertaining to access to food, participation in assistance programs, and information about periods when resources were inadequate to provide sufficient amounts of food. It could be administered through the U.S. centers for disease control.

Section 103. Development of the comprehensive plan. With regard to the comprehensive plan (b)(1), the design of future surveys should permit statistically reliable estimates not only of high risk groups but also of subnational geopolitical areas (page 11, line 10), (5) improve methods and technologies, including those suitable for use by States and localities (page 12, line 7); and (11) focus on national and State nutrition monitoring needs (page 13, line 6).

Section 106. Executive director and staff. With regard to the appointment of staff (c), the use of persons with qulifications such as those outlined in section 201(b) of this act would assure familiarity with the subject matter and greatly ease the work of both the directorate and the advisory council (page 17, line 6).

Section 107. Authorization of appropriations. With regard to the funding level of the centers for disease control competitive grants program, we suggest an appropriation of $1,000,000 annually, for each of nine succeeding years, to remain available until expended.

Title II. National Nutrition Monitoring Council.—The establishment of an independent, knowledgable and comprehensive outside advisory body will constitute a vital link between federal research and survey. Personnel and Outside Users. This body can assist the directorate in setting priorities for survey and methodological research; developing consensus as to uniform data elements for use in non-federal settings; consulting on data reports and interpretations needed by outside users; and otherwise expediting the transfusion of new scientific knowledge into practice.

Section 201. Establishment of the council. With regard to the total council membership (a)(2), we recommend a third category be added, namely for three non-voting members appointed from the directorate, with one each designated by the Secretary of Agriculture, the Secretary of Defense, and the Secretary of Health and Human Services, for terms not to exceed five years.

With regard to persons appointed to the Council by the President (c)(1), we propose that only directors or employees of nutrition research units, as outlined, be considered in this category.

With regard to representation on the Council (d), we recommend consideration of Farming or Agricultural interests.

With regard to officers of the advisory council (e), we recommend that the council should designate one member as its chairperson and one as its vice-chairperson for a term not to exceed five years. We believe that such self-governance promotes positive working relationships and thereby increases productivity.

This concludes our remarks, unless there are questions about these recommendations. We look forward to working with Congress and the administration to better meet the challenges of improving nutritional health through efficient and sensitive administration of public and private services.

Thank you.

REPORT SUBMITTED BY HON. WEBB FRANKLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

The following report has been prepared for submission to the House Select Committee on Hunger.

In the report, I have attempted to address the issue of food assistance programs in a historical context; to address the level of the government's commitment to food assistance in Mississippi; and to examine the specific circumstances of a number of individuals participating in food assistance programs.

I have included, as supplementary material, a number of recent newspaper articles addressing this issue.

I hope that the Committee's visit will be the first step in a comprehensive evaluation of this nation's food assistance systems.

I

"Mississippi, it seems to me, is, for its poor and particularly for its Negro poor, a kind of prison in which live a great group of uneducated, semistarving people from whom all but token support has been withdrawn . . . . Mississippi is not simply a medical emergency, it is a national disaster . . . ."—Raymond Wheeler, M.D., testimony before the Senate Committee on Labor and Public Welfare, July 1967.

Because of statements of this nature, Mississippi and poverty have always been synonymous.

That is understandable. Statistically, Mississippi has always had a disproportionate number of its citizens living below the poverty level. Mississippi has ranked on or near the bottom in per capita income, and many of the other statistical measures of prosperity. Infant mortality rates have historically been disproportionately high. Substandard housing has always existed.

Such a list could go on almost indefinitely.

It is not just a matter of statistics, it is a matter of perceptions as well. Many have, and will always have, an image of Mississippi as "a national disaster", and overcoming the perception is both a difficult and frustrating problem.

Mississippi continues to be thought of as a "worst case scenario" in terms of social problems. It is certainly true that social change has been slow in coming to the deep south, and our history of resistance to social change has been well documented. I think it is instructive, at this point, to put the preceptions to which I referred earlier into some sort of recent historical context.

For many people, perceptions of Mississippi were formulated in the 1960s.

In 1967, the Field Foundation commissioned the first independent physicians' study on hunger and poverty in Mississippi. In addition, a Senate subcommittee subsequently spent several days investigating in Mississippi, and holding hearings into the situation there.

Their findings paint a horrifying picture.

"In Delta Counties (such as Humphreys and Leflore) recently visited * * * we say children whose nutritional and medical condition we can only describe as shocking—even to a group of physicians whose work involves daily confrontation with disease and suffering.

"In child after child we saw: evidence of vitamin and mineral deficiencies; serious and untreated skin infections and ulcerations, eye and ear diseases, also unattended bone diseases secondary to poor food intake; the prevalence of bacterial and parasitic disease, as well as severe anemia, with resulting loss of energy and ability to live a normally active life * * * obvious evidence of severe malnutrition, with injury to the body's tissues * * *.

"We saw homes with children who are lucky to eat one meal a day—and that meal inadequate so far as vitamins, minerals or protein is concerned. We say children who don't get to eat fruit, green vegetables or meat * * *.

"In sum, we saw children who are hungry and who are sick—children for whom hunger is a daily fact of life and sickness, in many forms, an inevitability. We do not want to quibble over words, but "malnutrition" is not quite what we found * * *. They are suffering from hunger and disease and directly or indirectly they are dying from them—which is exactly what 'starvation' means."—Testimony of Drs. Joseph Brenner, Robert Coles, Alan Mermann, Milton Senn, Cyril Walwyn and Raymond Wheeler, July 1967.

That was only 17 years ago.

At the time of the report, there was intense disagreement over its validity and credibility. I do not doubt, however, that the doctors' group reported, essentially, the facts as they perceived them.

Their report, and subsequent hearings before the U.S. Senate, focused on a number of areas:

Lack of access, for poor blacks, to hospital facilities.

Arbitrary refusal of aid by county welfare departments.

A serious lack of food at both schools and pre-school centers.

Local governments' refusal, in many cases, to exercise their local option to participate in federal food assistance programs.

The 1968 Field Foundation report (Hunger U.S.A.) made a number of specific policy recommendations. Briefly, they include:

1. Federal food program should not depend on local or state option.
2. The basic federal food program should be free food stamps.
3. Eligibility should be keyed to income, dependents and medical expenses.
4. The law should recognize the special dietary needs of pregnant women, the aged, infants * * *.
5. School lunches should be made available to every child enrolled in Headstart through 12th grade.
6. The federal government and foundations should fund more research into diagnosis, treatment, cause and effect of malnutrition.
7. Private organizations should address themselves to these problems.

In 1972, an additional team of Field Foundation doctors investigated conditions in Mississippi. They subsequently issued a report entitled "Hunger U.S.A. Revisited".

During the time period between the 1968 and 1972 reports, modest, but undeniable progress was made.

Ten years after the original study, the same sequence of Field Foundation report, followed by congressional hearings was repeated.

In summarizing their 1977 findings, the Field groups had this to say:

"Our first and overwhelming impression is that there are far fewer grossly malnourished people in this country than there were ten years ago.

"In the Mississippi delta * * * where visitors ten years ago could quickly see large numbers of stunted, apathetic children with swollen stomachs and the dull eyes and poorly healing wounds characteristic of malnutrition—such children are not to be seen in such numbers. Even in the areas which did not command national attention ten years ago, many poor people now have food and look better off.

"This change does not appear to be due to an overall improvement in living standards or to a decrease in joblessness in those areas. In fact, the facts of life for Americans living in poverty remain as dark or darker than they were ten years ago.

"But in the area of food there is a difference. The Food Stamp Program, the nutritional component of Headstart, school lunch and breakfast programs, and to a lesser extent the Women-Infant-Children (WIC) feeding programs have made the difference.

"In a miserable shack in the Mississipi Delta, for example, the doctors visited a very poor black family of four adults and a half dozen young children. There was no plumbing or drinking water in the house. Heat was provided by unsafe open fires. The children were not receiving needed educational or health services.

"But in the midst of all this, in the one working refrigerator, there were fresh milk, and meat * * *. The food, purchased with food stamps, was the one difference from the situation ten years ago * * * and the children's health and liveliness reflected this (difference) * * *."

That feeling was echoed in Senate hearings in 1979. The title of the hearings—"Hunger in America: Ten Years Later."

Senator George McGovern:"Today, we will hear that 10 years after we began our efforts, millions of Americans are better off; poverty-caused malnutrition has been reduced. Poverty is still a fact of life, but in the area of food, there is a difference. . ."

Leslie Dunbar, the Field Foundation: "Under the economic conditions of the nation today, the Federal food programs play a vital role and do it well * * *."

Dr. Aaron Shirley, Jackson, Mississippi: "There is no doubt in my mind that the food stamp and other food assistance programs have made a difference * * *. In some instances, I believe the difference is even a matter of life or death * * *".

II

"Many of us who have been working the field of public health for the last decade have seen as a part of our own experience the changes brought about by WIC and other nutrition programs. It is there and it has been dramatic. . . Without these programs, we would no doubt return to where we were nutritionally 20 years ago."—Dr. Earl Fox, Chief of Bureau of Personal Health Services, Mississippi State Department of Health, November 1983.

What has been the nature of the government's commitment to improve nutrition in Mississippi.

Using the original Field Foundation recommendations as a backdrop, it is easy to trace the dramatic changes referred to in Dr. Fox's statement.

Recommended: that federal food programs should be available to the needy of every locality and should not depend on local or state option * * *.

Local option is no longer the case. While many Mississippi counties, frankly, had to be coerced into participation in the full range of federal social welfare programs, the fact is that every Mississippian now has reasonable access to said programs.

Recommended: the basic federal food program should be free food stamps * * *.

When the switch was originally made from commodity distribution to food stamps, program recipients were almost unanimoulsy of the opinion that they did not want the food stamp program. Essentially, their reason was that they could not afford to buy the stamps.

In 1970, the Nixon administration made free food stamps available to persons with zero income. In 1971, Congress revised the Food Stamp Act to comply with that policy.

Recommended: eligibility for food stamps should be keyed to income, dependents and medical expenses * * *.

In the 1971 revision of the Food Stamp Act, nationally uniform federal standards were established for eligibility determination. Previously, requirements had been left up to each state. Under this revision, eligibility is determined by three factors: income, assets, and job search.

Income limits are determined by making certain deductions from the cash income of the household. The allowable deductions are:

(A.) A standard deduction—currently $89—that is indexed to inflation.

(B.) 18 percent of any earned income.

(C.) Any work-related expenses for the care of a dependent, up to $125 per month per household.

(D.) Out-of-Pocket medical expenses for elderly or disabled members of the household, to the extent that they exceed $35 per month.

(E.) Shelter expenses, to the extent that they exceed 50 percent of countable income after the above deductions have been made.

The assets test sets a limit of $1,500 in liquid assets for a single person; $3,000 for two or more persons. This excludes the value of a residence and a portion of the value of a car. If a family receives AFDC payments, they are not required to meet the assets test.

According to the 1971 revision, all able-bodied adults must register for, seek and accept suitable employment unless caring for a dependent.

In Leflore County, Mississippi, 27 percent of the population receives food stamp assistance.

In addition to the Food Stamp Program, commodities from USDA are distributed every three months. Items available include cheese, butter, cornmeal, flour, honey, dried milk and rice. Beginning in August, 1984, commodities will be distributed on a bi-monthly basis.

Currently, the maximum value available for a three-month period is $28.92 per household.

Recommendation: the aim being to achieve adequate diets, the law should recognize the special dietary needs of pregnant women, the aged, infants, the sick, and perhaps others * * *.

The Women, Infants and Children (WIC) program is perhaps the most important adjunct to existing health services that is currently available.

In Mississippi, WIC benefits are distributed in the form of food packs which are picked up by participants. There are 152 clinics in 82 counties providing WIC services.

Mississippi is the only state in the nation to buy WIC commodities directly from suppliers on a low-bid basis. That system has resulted in a total average value of $24.12 per food pack—$9 lower than any other state. Add $7 of administrative costs to that figure and the total cost of the program per case is $31.12, the lowest cost program in the nation.

Two different types of food pack are distributed. One is for women and children over age one year. The other is for infants.

Women and Children Pack

Milk products:
  cheese
  nonfat dry milk
  evaporated milk

Cereal products:
  brands containing 40 percent

  RDA of Iron

  Hot oatmeal

Juice: orange, grape, pineapple
18 oz. jar peanut butter
Eggs (dry mix)

Infant Pack

31 cans of infant formula
At age 4 months, add: cereal
At age 6 months, add: infant juice

In 1975, 7,890 Mississippians participated in WIC. The cost to the federal government was $1.03 million.

By April, 1984, Mississippi served 86,857 participants—57 percent of the potentially eligible population. The cost outlay has grown as well—to over $26 million.

In Leflore County, there were 2,465 participants as of April, 1984. Mississippi's percentage of coverage is one of the highest in the nation.

The needs of our nation's elderly citizens have been addressed as well.

The Older Americans Act authorizes grants to state agencies on aging to develop a comprehensive and coordinated delivery system for supportive services, nutrition services and multi-purpose senior centers for older persons. In Mississippi, the Governor's Council on Aging distributes funds through the area planning and development districts. Funds from Social Services block grants are utilized as well.

Funds are alloted for the operation of congregate nutrition services and home-delivered nutrition services. These services are available to individuals aged 60 or over and their spouses of any age, and to handicapped or disabled persons under 60 years of age who reside in housing facilities where congregate meals are served, and which are primarily occupied by elderly persons.

Recreation activities, as well as nutrition and shopping education are provided at the meal sites periodically.

In Leflore County, Mississippi, there are four congregate meal sites: the Johnson Street Center and the Threadgill School center, both in Greenwood; and Sidon Town Hall Center in Sidon; and the Brozie Community Center in Itta Bena. Meals are served five days a week.

In fiscal year 1984, for the 17 nutrition sites and home-delivered meal operations conducted by the North Central Planning and Development District (which includes the Leflore County area), the following amounts were allocated:

	Older Americans title III	Social Services title XX
Congregate	$234,796	$93,307
Home delivered	63,777	54,503

The following adjunct services are also available:

Transportation: 23 vans operate in a 7-county area, and transport elderly citizens to nutrition sites (as well as doctors' offices, government assistance offices and shopping areas). Both Title III and Title XX funds are available for this.

Senior Employment: In fiscal year 1984, $54,632 was available in the 7-county area for the employment of workers 55 and older to help provide meals and other services at nutrition sites.

Information and Referral: In the 7-county area, a phone line is provided so that elderly may call to get information on available programs, transportation information and other information.

Recommendation: in furtherance of the resolve that every child have an adequate diet, we believe that school lunches should be available to every child enrolled in public, private or parochial schools up to and including 12th grade, as well as in kindergarten, Headstart or other pre-school centers, nursery school and day care centers * * *.

Under the existing school lunch program, meals served are either free, or at a reduced price, depending on income levels.

A family of four with income of less than $12,870 is eligible for the free lunch program. A family of four with income of less than $18,315 is eligible for the reduced price lunch program. Under the reduced price program, up to $.40 may be charged.

In 1981–82, the national average indicated that 50 percent of the meals served in a given school were free or reduced price. In Mississippi, that figure was 80 percent.

Of all the lunches served in public schools in Leflore County, Mississippi, during the current school year, 86 percent were free. Four percent were reduced price. Ten percent paid the full price.

The eligibility requirements for the school breakfast program are the same as for the lunch program: families whose income is less than 130% of the poverty level are eligible for free meals. Reduced price meals are available for families between 130 and 185 percent of the poverty level.

In Mississippi, 559 schools participate, about 400 less than the total participating in school lunch. Most of those participating are elementary schools.

During the current public school year in Feflore County, Mississippi, over 170,000 breakfasts have been served. Over 164,000 have been free. This is less than half the number of lunches served.

Recommendation: either the Department of Health, Education and Welfare or the Office of Economic Opportunity should be directed and funded to employ and soundly train a large number or food stamp recipients as nutrition and health care extension workers among the poor * * *.

Realistically, there seems to be a breakdown in the system where nutrition education is concerned.

Under the federal guidelines of the WIC program, a portion of the administrative funding is required to be used for nutrition education. All WIC participants receive nutrition training or their initial visit either by a nutritionist or by the attending nurse. The focus is on the participant's individual nutrition needs. There is no mandatory nutrition training or education after that initial visit.

In Leflore County, Mississippi, a qualified nutritionist is available 11 days per month to meet with participants. Additionally, the WIC coordinator for a nine-county area is a nutritionist, and is available on occasion.

The County Health Department conducts clinics to discuss the special needs of pregnant women and infants. In Leflore County, the WIC officials have indicated that their primary problem is a general lack of interest by participants.

One day a week, there is a nutrition aide available at the WIC warehouse to talk with participants as they pick up their packs. She conducts food demonstrations on the use of WIC foods. The lesson plans used are developed by the department's nutritionist. There are also budget recipes and menus available free at the WIC warehouse.

In Leflore County, there are four qualified nutritionists. Two work in the private sector.

Recommendation: private organizations concerned with human welfare will address themselves to this most elemental of all of humanity's problems * * *.

To some extent, private organizations have responded to the above challenge. I will comment on those organizations in Leflore County, Mississippi which I know have addressed themselves to this problem:

St Francis Catholic Center—The St. Francis Center offers a broad range of assistance to families, in need: transportation, assistance in acquiring items such as clothing or eyeglasses, and food assistance. The Center distributes items such as chicken, potatoes and milk periodically to needy families, workers estimate that between 75 and 100 requests of various types are made each week to social workers at the center. Figures on food distribution were not available.

Salvation Army—The Salvation Army in Greenwood offers food packages to indigent families whenever requests are made. Captain Wayne Schneider say that 19 cases have been handled by the Salvation Army during the period June 1-20. The agency sponsors a Christmas assistance program as well, providing approximately 450 families per year with food, clothing, and gifts. Captain Schneider says that it is his general impression that many of the families served at Christmas are the same from year to year.

Greenwood Junior Auxiliary—Through an outreach program, the Junior Auxiliary provides a number of services on a referral basis from local churches, civic organizations and other groups. Services provided include transportation assistance, emergency need money, intercession in eviction cases, clothing, food assistance and other general types of assistance. Approximately 200 households per year are served in some way or another.

St. John's Methodist Church—In cooperation with the North Mississippi Planning and Development Agency's lunch program for the elderly, volunteers from St. John's deliver meals to homebound recipients on a daily basis.

Greenwood Ministeral Association—Local churches contribute to a fund for transients. No figures are available on the number currently served.

It is possible that there are other volunteer organizations doing work in this area on an ongoing basis. I am not aware of them at this time.

In summary, nutrition programs have had a profound effect on Mississippi.

That effect can be most graphically traced through infant mortality statistics.

In 1960, the infant mortality rate was as follows:

Mississippi—1960

White	26.3
Non-white	54.4
Total	41.5

United States

White	22.9
Non-white	43.2
Total	26.0

[Figures represent deaths under one year of age per 1,000 live births.]

The following are 1980 statistics:

Mississippi—1960

White	11.0

Non-white	23.3
Total	17.0

United States

White	11.0
Non-white	19.1
Total	12.6

During that 20-year period, the national infant mortality rate dropped by 14.3 percent. In Mississippi, it dropped by 24.5 percent. Obviously, Mississippi had further to come, but the improvement is there.

Further, it should be noted that infant mortality occurs most often with mothers who qualify as mothers-at-risk. These are mothers who are too young, undereducated or poor, or who do not have access to appropriate care. According to the Mississippi State Department of Health, more than half of the babies born in Mississippi in 1982 were born to mothers-at-risk.

III

"Has the war on hunger been won here in the Mississippi Delta? Thanks to massive and continuing federal assistance, at a level two to three times that elsewhere, clinical malnutrition seems to have been eliminated . . . with such a fragile balance between federal assistance and human need, the challenge, say officials, is to make sure it doesn't tip in the wrong direction * * *."—Rebecca Chase, ABC News September 1983.

"Emergency in Mississippi", "Medical task force finds poor blacks in delta area near starvation"—Headline, Boston Sunday Globe, May 13, 1984.

As I stated earlier in this report, this issue too frequently becomes a matter of perceptions; perceptions formed by splashy headlines and brief images.

Have we progressed or have we regressed? Are people hungry, malnourished, near starvation, or none of the above? I do not think we can rush to judgment in dealing with these questions. I also, personally, can not be content to rely solely on the facts as they have been portrayed through the media, or by independent investigators. I do not think that anyone should make a judgment based on newspaper accounts alone, or on undocumented evidence.

In May of this year, the Field Foundation again sent a group of investigators into Mississippi and other places to address the issue of malnutrition and hunger in America. Both hearings and home visits were conducted in my hometown of Greenwood, Mississippi.

I was not invited to participate in those hearings. I am not aware of any report that has been issued by the Field Foundation group.

Their visit, however, has again focused a great deal of national attention on social problems in the state of Mississippi. I have seen, and I have included with this report, a number of media accounts of "worst case" examples, of families with little or no food on hand, and little idea of where their next meal might come from.

It is impossible not to be affected by the human misery described in those newspaper accounts. Furthermore, I have little doubt that the media has offered a fairly realistic account, in the majority of cases, of the circumstances which were observed in the homes they visited. The cases they highlighted only scratched the surface of the social problems that exist in the Leflore County area, but none of them sufficiently address the question of why these problems exist.

After the Field Foundation visit to Greenwood, and after compiling what information I could about their visit, I instructed my stafff to do the following:

To visit the homes of those individuals who were listed in newspaper accounts as being in need of food.

To determine if, through the appropriate channels, there was any government assistance we could help them obtain or apply for.

To obtain, from other service providers and agencies, specific information on other families or individuals needing assistance in the Greenwood area who were not subjects of the Field Foundation study.

My staff members are not health professionals; neither are they trained investigators. They visited these homes during May and June, 1984, and recorded the facts as best they could.

Wherever possible, we have confirmed facts and figures with local assistance agencies. We have also attempted to summarize, with assistance from the USDA

Food and Nutrition Service, the monthly benefit levels available in the households visited.

Information gathered during those visits is as follows:

CASE NO. 1

This case was obtained through a local agency which participated in the Field Foundation investigation. Her case was referred to us as being a typical case subject of that investigation.

The head of household is a 68 year old black female residing at 612 Walthall Street, Greenwood. Other occupants of the dwelling include a grandson, age 18, and his father, who has only recently moved into the home.

Her five-room wooden house contains inadequate plumbing, is poorly insulated, and in generally poor condition. She has resided there for nine years. She pays $125 a month in rent. The average gas bill during the winter is approximately $100. Her average utility bill during the summer is approximately $50.

Currently, the family's only income is $220 per month in Social Security benefits.

When asked why she received no other assistance, she stated the following (this is not an exact transcription): "I once received food stamps through the Leflore County Food Stamp Office. However, my grandson, who presently is in the Navy, was disclosed as having sent $100 a month to me so that I could maintain my household. As a result of this, the Food Stamp office discontinued assistance. You can tell Mr. Franklin that I remember walking the streets of Greenwood many a day hungry. But I was too proud to beg. But now with my son-in-law and grandson both here I might have to beg if we run short."

The head of household owns approximately 50 cats. The cats, she claims, eat before she does.

My staff has determined that she is eligible for $116 a month in food stamp assistance. Steps have been taken to enroll her in the food stamp program. She stated she is unaware of any other federal assistance for which she might qualify, and my staff is presently helping her to qualify for participation in the surplus commodity and energy assistance programs.

Her son-in-law is a 54 year old black male who formerly resided at 808 Fulton Street, Greenwood. He lived there with his wife, and four stepchildren until June 8, 1984.

He is a stroke victim. He reportedly lost his speech in November, 1983.

At one time, he received Supplemental Security Income of $219.99 a month. This was discontinued upon the Social Security Administration's discovering that his wife was misusing his benefit check. The Social Security Administration was informed of that fact by a neighbor. His wife confronted the neighbor; an argument ensued, and the neighbor (name unknown) shot her.

Upon being discharged from the hospital, she threw her husband out of the house.

At the time this man was located by my staff member he was poorly dressed, hungry, and crawling outside his mother-in-law's home. He had no income, needed medical attention, clothing and grooming.

My staff has arranged for his food stamp case to be reopened; additionally, we have arranged for reinstatement of Social Security benefits. We have arranged for him to receive medical attention and clothing, and, as of this writing, he is said to be markedly improved.

CASE NO. 2

This case was obtained through a local social service agency which participated in the Field Foundation investigation. The case was referred to us as being a typical case subject of that investigation.

The head of household is a 27 year old black female residing at 800 Cotton Street, Greenwood. She has six children, ages two through ten, all residing at that address, Her common law husband does not live at that address.

The family lives in a four room wooden dwelling which is in generally poor condition. They have resided there for three and a half years. The rent is $65 per month. The head of household feels the house should be condemned for various reasons: no hot water, inadequate plumbing, missing windows, cracking walls, and a leaky roof. Her average gas bill during the past winter was approximately $200 per month.

She is unemployed, and has never been employed. She has received Supplemental Security Income benefits of $314 a month for several years. Her son, age 8, receives $314 per month from the Social Security Administration and is enrolled in special education classes. She recevies $96 per month in ADC benefits.

She receives $159 per month in food stamps. All her children participate in the school breakfast/school lunch program. The family also participates in the Surplus Food Distribution program.

Her daughter, age 2, is recovering from meningitis. Her son, age 8, is currently in the Greenwood Leflore Hospoital with serious burns over his back and arms. He received his injuries when a pan of boiling water, which his mother was heating for bathwater, fell on him. The Leflore County Welfare Department has reprimanded the mother because of the frequent injuries her children incur. Three of her six children have been run into by automobiles.

She states that sometimes she receives enough food assistance and sometimes she doesn't. On the day of the staff visit, the family breakfast consisted of pimiento and cheese, and crackers.

My staff members are monitoring the health condition of the young son. They have referred the mother to the local welfare department for nutrition counseling.

Cash value of assistance

SSI	$628
ADC	96
Food Stamps	159
Total	883

The family also participates in school lunch/breakfast and receives surplus commodities.

CASE NO. 3

This case was obtained from through a newspaper article in the Greenwood Commonwealth which appeared during the Field Foundation investigation.

The article, which quoted the head of household, portrayed the household as an example of a hungry family.

The head of household is a 31 year old black female residing at 303 West Gibbs, Greenwood. She has five daughters, ages five through 14, all residing at that address.

She lives in a four room wooden dwelling in generally poor condition. She has lived there for six months. She pays $85 a month rent. She says she has requested that the landlord make needed improvements, but he has refused to do so. Her average gas bill during the winter is approximately $162 per month; her average utility bill during the summer is approximately $80 per month.

She is unemployed, and has been unemployed for 10 years. Her oldest daughter will receive Supplemental Security Income benefits of $314 per month beginning in July. Another daughter receives $314 per month in SSI benefits at the present time. The mother receives $120 per month under the ADC program.

She receives $274 per month in food stamps. She stated that this amount will be cut to $170 in July because of the expected increase in her daughter's SSI benefit check. She says that she feels the food stamps are adequate to meet the nutritional needs of her family, and that they eat out frequently. She did complain that frequently she has to wait for a long period of time at the food stamp office. She stated that she was embarrassed that she appeared in the local paper during the time attention was given to hungry families. She says that her neighbors jeered at her, and her children were ridiculed at school. She states that her family is not hungry.

She further states that she is unaware of the Surplus Food Distribution program, as well as the energy assistance program. My staff has informed her of the proper procedures for enrolling in those programs. My staff is also investigating other housing in Greenwood which might be suitable for her family.

Cash value of assistance

SSI	$628
ADC	120
Food Stamps	274
Total	1,022

CASE NO. 4

This case was obtained from an article in the Boston Sunday Globe which appeared after the Field Foundation investigation.

The family was portrayed as "near starvation" by the newspaper account.

The family lives at #13 McClure's Alley, Greenwood. Also residing there are seven children, ranging in age from 10 to 25, and four grandchildren.

The family lives in a four room dwelling in extremely poor condition. The house is poorly insulated, and the doors, windows and floors are in obvious need of improvement. Flies, other insects and rodents are clearly visible. The rent is $75 per month. There is no stove and no refrigerator. At the time of the visit, my staff was informed that the gas had been turned off, allegedly due to failure to pay a $65 gas bill. A representative of Mississippi Valley Gas claims that the bill was several hundred dollars, and had not been paid in several months.

The head of household claims that the money for the gas bill was used to admit her son, age 25, into the Greenwood Leflore Hospital. When visited in the hospital on June 2, he disputed that claim. He claims that he frequently checks into the hospital free of charge. Currently, he is diagnosed as having tuberculosis in one lung; he says that his doctor tells him that condition is a result of excessive cigarette smoking. He is unemployed, and claims that he gets cigarette and beer money by cashing in $50 worth of food stamps for $20 cash at a local grocery store. At the time of the visit, he claimed to be uncertain as to whether or not he would look for employment after his release from the hospital.

The head of household is unemployed, and has been unemployed for three years. She has been to the local employment office on one occasion since then.

One daughter, age 14, is the mother of three children, and participates in the WIC program. The household receives $120 per month in ADC benefits for these three children. The benefits are administered by the head of household since the mother is still considered a minor. The household receives $438 per month in food stamps. One son, 18, receives $314 per month from Supplemental Security Income. All eligible children participate in the school lunch/school breakfast program. The family participates in the surplus food distribution program. The family also receives assistance through the St. Francis Center.

The head of household says that the family eats a lot of "fast food", i.e. wieners, potato chips, and other snack foods. She said that her family is definitely hungry.

My staff has determined that this household receives the maximum available food assistance. We are investigating to see if the household qualifies for energy assistance.

Cash value of assistance

ADC	$120
Food Stamps	438
SSI	314
Total	872

The family also receives WIC benefits, surplus commodities and school lunch/breakfast.

CASE NO. 5

This case was obtained through a newspaper article in the Jackson Clarion Ledger which appeared after the Field Foundation investigation.

The head of household says she often asks a local charity to help feed her 22 family members. "The stamps last about three weeks, then we just have to make out as best we can," she said.

The head of the household is a 48 year old black female residing at 116 East Johnson Rear, Greenwood. She has 11 children, ranging in age from nine to 28. Residing there are daughter A and her five children; daughter B and her four children; daughter C and her son; daughter D and her three children; daughter E and her son; also three sons and an unrelated male. Three other sons are in the state penitentiary. The total number of residents in the household is 24.

The family lives in a seven room house that is in generally poor condition. At the time of the visit, the house contained numerous beer cans and cigarette butts. The rent is $150 per month.

The household receives $970 per month in food stamps. Daughter A receives $96 per month in ADC benefits for two of her children, plus $314 SSI for another. The father of two of her children also resides in the home. Because he lives there, those two children are not eligible for ADC benefits. Daughter B receives $144 per month in ADC benefits. Daughter C receives $60 per month in ADC benefits. Daughter E receives $60 per month in ADC benefits.

Daughter D, age 22 is a deaf mute. She receives $314 per month in Supplemental Security Income benefits. Her mother receives $168 in ADC benefits per month for her three children. The head of household says that she is not aware of any income that her three sons living at home might have.

The family also receives $32 per month SSI for two other children.

All school age children participate in school lunch/school breakfast programs. All eligible infant children and their mothers participate in the WIC program. The household also receives assistance under the Surplus Food Distribution program.

The head of household stated that the welfare and food stamp system does not provide enough to feed her family. She said that she has often asked for help through the St. Francis Center, but she says she has received no assistance through that organization in approximately three months. Personnel at St. Francis say that this is not the case, and that she receives assistance from the center frequently.

My staff has concluded that this household receives the maximum available in food assistance. We are investigating to see whether or not they are eligible for energy assistance.

Cash value of assistance

Food Stamps	$970
ADC	528
SSI	660
Total	2,158

Additional benefits are surplus commodities, WIC, and school lunch and breakfast.

CASE NO. 6

This case reference was obtained independently from the Field Foundation investigation.

This is a 78 year old white female residing at 200 Fifth Street, Apartment #1, Greenwood. She is blind. She also has diabetes and recurring heart trouble.

The lives in a four room apartment, where she has lived for six months. She pays $110 per month in rent. Utility and gas bills, combined, total approximately $50 per month. She also has medical bills averaging approximately $40 per month.

Her only income is $414 per month from Social Security. Because of her blindness, her bills are now paid through a local bank. In January, 1984, she had approximately $900 in a savings account. She now has a balance of $225 in savings.

She stated that she would like to receive surplus commodities. She stated that she was aware that there were organizations that provided home delivered meals, but it was her impression that the home delivery service was costly.

As result of our investigation, steps have been taken to allow her to participate in both of the above programs. Steps have also been taken to enroll her in the food stamp program. Beginning in July, she will receive food stamp benefits of $49 per month.

Cash value of assistance

Social security	$414
Total	414

CASE NO. 7

This case was obtained independently of the Field Foundation investigation.

The head of household is a 68 year old white female residing at 206 Fifth Street, upstairs apartment. Also residing there is her son, age 41.

They live in a four room apartment in generally fair condition. She pay $90 per month in rent. Utility bills average approximately $40 per month. Gas bills average approximately $30 per month.

She receives Supplemental Security Income benefits of $314 per month. She receives $52 per month in food stamp benefits, which are mailed to her.

She stated that the food stamps she receives provide only minimal help. She subsists primarily on a liquid diet (orange juice, beef broth, etc.)

Her son has a collapsed lung, and suffers from mental problems. He cannot be gainfully employed, and has no income. When asked why he did not receive SSI benefits, his mother stated that he was "too proud to ask for help." His mother stated that she would try to encourage him to get some assistance.

Cash value of assistance

SSI	$314

Food Stamps	52
Total	366

CASE NO. 8

The case reference was obtained independently of the Field Foundation investigation.

The head of household is a 41 year old white male residing at 1907 Portwood Street. Also residing there are his two daughters, ages two and three, and his mother, ager 78.

This family lives in a four room house in generally poor condition. They pay $50 per month in rent. Utility bills average approximately $30 per month, and range as high as $80 per month during the winter.

The father has been unemployed since March, 1984. He receives $82 per week in unemployment. His mother receives Supplemental Security Income benefits of $334 per month. The family does not receive food stamp or WIC benefit.

Both adults in the household stated that the family has enough food. The father claims that he fixes three meals per day.

As a result of the staff investigation, an appointment has been made for him to arrange participation in the WIC program, and other assistance programs, including food stamps, surplus commodities and energy assistance.

Cash value of assistance

Unemployment ($82/week)	$328
SSI	334
Total	662

CASE NO. 9

This case was obtained independently of the Field Foundation investigation.

This is a 70 year old white mile residing at 210 First Street North, Greenwood. He has lived there for eight years. He pays rent of $85 per month. His utility bill averages approximately $36 per month; his gas bill averages approximately $30 per month. During the winter, his bills range as high as $56 per month.

He suffers from heart trouble and vascular problems, and incurs occasional medical expenses as a result. He did not specify the total of those expenses.

He receives $334 per month in Social Security benefits. He also receives $10 per month in food stamps, which are mailed to him.

He supplements his food stamp purchased through his garden, and through participation in the surplus commodity distribution program. He states that he smokes approximately two packs of cigarettes per day. From their visit, it is the general impression of my staff members that he drinks heavily. He says that there have been some times within the last year when he was actually hungry.

My staff has made inquiries regarding his eligibility for home delivered meals. Additionally, he has been referred to the St. Frances Center.

Cash value of assistance

Social Security	$334
Food Stamps	10
Total	344

He also participates in surplus commodity distribution.

CASE NO. 10

This case was obtained through a social service organization which participated in the Field Foundation investigation.

The head of household is a white female in her late twenties. She currently resides at 125 James Street with her nine year old daughter and a male relative. She pays $100 a month in rent; she states that she is currently $50 behind on her rent. She moved to Greenwood in August, 1983.

She is unemployed. Her only income is $180 per month for her daughter from her father's disability. She participates in the Work Incentive (WIN) Program sponsored through the Leflore County Welfare Department; through that program she will soon be placed in a clerical position as part of an on-the-job training program.

She receives $106 per month in food stamps. Her daughter participates in the school lunch/breakfast program. She states that she is not hungry but has to be extremely careful in spending her money. She further states that she would like to be able to make it without food assistance programs.

Cash value of assistance

Disability	$180
Food Stamps	106
Total	286

CASE NO. 11

This case was obtained independently of the Field Foundation investigation.

This couple is white; both are 25 years of age. They reside at 106 Winchester Street, Greenwood. Also residing there are their two children, ages five and nine months. The mother is currently four months pregnant.

The family resides in a seven room house in extremely poor condition. At the time of the visit, there were numerous beer cans and cigarette butts strewn around the house. There are also several cats living in the house. There is no hot water. They pay $80 per month rent. Utility bills average approximately $40 per month.

The father is employed by a local plumbing company, earing $142 per week. The family receives $109 per month in food stamps. The family participates in the WIC program.

They pay $40 per month in car payments on a car which has been repossessed. He also pays $60 per week in truck payments. The family is able to charge groceries at a local store: they charge approximately $100 per week.

My staff members have advised the mother on how to apply for energy assistance and surplus commodities.

Cash value of assistance

Earnings	$568
Food Stamps	109
Total	677

IV

"One thing I regret is when people traveling with us make statements about getting somebody out of office. Hunger should be a bipartisan issue."—Larry Brown, Chairman of the Physician, Task Force on Hunger, as quoted in the Jackson Clarion-Ledger May 16, 1984.

"Larry (Brown) said before we came here that we want to make a political impact. That is the hidden agenda * * *." when we write up the report, it will be used as a political tool * * *."—Dr. Maxine Hayes as quoted in the Jackson Clarion-Ledger, May 16, 1984.

I have little doubt as to the sincerity of the so-called "hunger fighters"—the Field Foundation groups and others.

I think that in past years they have performed a valuable function in raising the consciousness of Mississippians where hunger is concerned. Particularly in the 1960s, that was both worthwhile and necessary.

I think, however, that a narrow, sensationalized approach to this issue can serve no constructive purpose.

On the contrary, it seems to me that this kind of approach does several things. First of all, there is the matter of the image of Mississippi that such efforts perpetuate.

During May, 1983, the Physician Task Force visited an unspecified number of homes. They made no apparent attempt to vist homes in white communities. They did not research to verify the accuracy of claims that were made to them.

In a number of the homes they visited, they found no food on hand. And as a result, the picture painted for the rest of the world is one of "poor blacks near starvation."

If the Task Force made any effort to find out why those individuals were hungry, I am not aware of it. If the Task Force made any attempt to suggest ways in which those individuals might find help, ways in which they might avail themselves of more adequate government assistance, I am not aware of it.

I understand from the articles I have read that the Task Force is interested in letting the world know what they saw in Mississippi.

I suggest that they saw a state which has made dramatic progress, perhaps more than any other states, in assuring its citizens an opportunity to feed themselves.

I suggest that they saw a state in which federal food assistance programs have a proven, successful record of meeting their stated goals; a state in which the benefits provided through those programs have steadily increased.

I suggest that they saw a number of individuals who simply are not aware of the full range of benefits available to them. In many cases, their situations have already been simply by matching the individual with the appropriate program or agency.

I also suggest that they saw a state that still has a long way to go. I believe that all of us who have seen the progress of the last two decades recognize that fact.

If people are hungry—and I believe that there are people who are hungry—their problem can only be understood within a larger context.

For example, in many of the "worst case" households which we visited, housing is perhaps the overriding social problem.

I refer back to the descriptions in the individual case studies:

"Five room house contains inadequate plumbing, is poorly insulated, and in generally poor condition * * * pays $125 a month in rent * * * average gas bill during the winter is approximately $100 * * *."

"Four room wooden dwelling which is in generally poor condition * * * pays $65 per month in rent * * *. She feels the house should be condemned for various reasons * * * average gas bill during the past winter was approximately $200 per month * * *."

"Four room wooden dwelling in generally poor condition * * * pays $85 a month rent * * * average gas bill during the winter is $162 per month * * *."

"Four room dwelling in extremely poor condition * * * house is poorly insulated, and the doors, windows and floors are in obvious need of improvement * * * pays $75 per month rent * * * gas had been turned off, allegedly due to failure to pay bill * * *."

I have concluded that the nutritional problems that those individuals may experience are due, in large part, to value decisions they must inevitably make. The money to buy foood is there. The decision, however, often boils down to a decision of food vs. shelter.

I realize that housing is not the primary focus of this debate, but the problems of a large number of these individuals living below the poverty level in Mississippi can only be solved by a federal commitment to ending sub-standard housing which equals the federal commitment to ending hunger we have seen in the last 20 years. I am committed to work toward that goal.

I also suggest that the Task Force found a number of individuals who, through circumstances beyond their control, are unable to administer the benefits they do receive in an effective manner. For these individuals, I think the government needs to reassess its commitment to nutrition education. There are several legislative initiatives which would address this sitution currently before the Congress, and I look forward to monitoring their progress.

I have concluded that there are ways in which Mississippi program administrators have been truly innovative. The administration of the WIC program is an example, and the people responsible should be commended. WIC, in particular, is a program in which recipients get maximum value out of the benefits received, and I think continued strong funding for this program is necessary.

I have also concluded that there are ways in which federal nutrition assistance might be redirected. In the home-delivered meals program for the elderly, for example, there are people on a waiting list in Leflore County. I think it would be appropriate to examine the feasibility of a means-test for that program.

Also, it goes without saying that in Leflore County, as in the nation at large, there is always room for more private sector participation, and a renewed spirit of "neighbor to neighbor" type assistance. Despite the many fine efforts that are made, I think it is unfortunate that there seems to have been a nationwide trend away from such involvement. I think this is due, in large part, to a general feeling that the responsibility for such assistance has been assumed more and more by the federal government.

I would agree wholeheartedly with the quotation that introduces the above section of this report: hunger should be a bipartisan issue.

Obviously, that is not always the case. The fact is that Mississippi has always been a convenient target for those who want to make a political impact.

The irony of that fact is that such a partisan, politically charged debate can only reinforce the image Mississippi has in the rest of the world. While we have hardly solved all of the problems existing in our society, we have certainly make remarkable strides. That is the story that the world needs to hear, but, unfortunately, that is not the story that makes national headlines.

I think the leadership of Mississippi, both black and white, understands the nature and the consequences of this most frustrating dilemma.

We can never truly eliminate the poverty and dependency cycle in Mississippi without continued economic development.

We can never attract the investment necessary to develop our economy, in my view, if a negative image of Mississippi is perpetuated through the national media.

We can never overcome that negative image as long as the outside world is not allowed to hear the real facts.

It is a vicious cycle. The future of our state, in a very real sense, depends largely on our ability to break out of it.

Additional material submitted by Congressman Franklin retained in subcommittee files.

PREPARED STATEMENT OF CAROL GRIGGS, MSW, AND JANICE ALEXANDER, BSW, DELTA HEALTH CENTER

Delta Health Center serves approximately twenty three thousands (23,000) patients per year. Of this number eighty percent (80 percent) of them fall on or below the poverty level. The majority of the clients served receive food stamp assistance but have very little or no income coming into the home. When an emergency occurs, such as illness or the need for medication arises, individuals are forced to illegally sell food stamps to obtain money. Individuals are responsible for bills and other living expenses, even if this only incorporates utility bills. The assistance checks received by most Mississippi recipients are not enough to carry them over from month to month.

To combat some of nutritional problems facing patients at Delta Health Center, two departments were created: Women Infant and Children WIC) and Nutrition. Eighty Percent (80 percent) of the clients served by Delta Health Center WIC Department have a lack of education as to proper foods and nutrition. Teenage mothers do no know how to prepare formulas and some infants seen suffer from failure to thrive. Most patients do not know how to shop for foods with nutritional value; therefore, the problem of malnourishment is enhanced.

A large number of patients served at Delta Health Center are obstetrical patients. Most OB patients suffer from excessive weight gain due to ignorance as to proper dieting. A big problem with teenage pregnancies is premature deliveries and poor nutrition. Approximatley 108,000 individuals participate in the WIC program each year.

The nutrition department provides counselling for diabetics, overweights, underweights, and pregnant women. Approximately sixty percent (60 percent) of clients seen in this department have a lack of knowledge as to the preparation of a well balanced diet. Extensive counselling is done to patients on the basic concepts of the nutritional value of foods. For illiterate individuals, audio visual aids are available.

In 1980, an outreach program was devised. It's main objective was to contact those individuals in the service area who are not able to come into the Center due to certain circumstances, i.e. lack of transportation, and provide nutritional counseling to them. Due to a lack of funding, this service was terminated in 1982. As a result of this termination, people in rural areas are unaware of the possible aid available to them.

Suggestions to achieve maximum effectiveness in the services provided.

1. To reduce the incidence of nutritional suffering, individuals must be educated on proper diet and shopping habits.

A. Individuals may receive the benefits but if they are unaware of their proper usage, services are not worth while.

B. A nutritional service should be provided for the purpose of educating individuals on the basic four food groups and how to prepare a well balanced diet.

2. The attitudes and personalities of some employees responsible for the distribution of service are so negative and harsh that individuals are discouraged from seeking benefits.

A. Efforts should be made to increase the professional atmoshpere in the agencies providing service.

3. In many instances, time between appling for services and receiving benefits can be so long that people are forced to do without for some period of time. Very little communication is upheld between the client and the supportive agency.

A. Attempts should be made to decrease the amount of time it takes to complete application and receive benefits.

B. Mississippi should adopt an emergency assistance system where individuals can receive aid when they first apply until the regular benefits become effective.

DELTA HEALTH CENTER

HISTORY

The Delta Health Center opened in the Fall of 1967. It came into being through the efforts of Dr. Count Gibson, head of the Department of Preventive Medicine, Tufts University and Dr. Jack Geiger, Professor in the Department of Preventive Medicine, Tufts University. The Center opened as the sister facility of Columbia Point Comprehensive Health Center, Boston, Massachusetts. Drs. Gibson and Gieger were able to receive funding from O.E.O. for two projects, one rural and the other urban, to demonstrate that an ambulatory health facility could function as a health maintenance mechanism as well as a disease prevention mechanism.

The impact on the health of residents in North Bolivar County was immediately seen. Many of the poor in this area did not have a doctor—most of the residents have never visited a doctor. So the first six months of the Center's existence were spent treating diseases. Soon it began to dawn on the medical providers that many of the diseases they were treating were caused by environmental factors. Treating the disease was like smoothing the surface while the underlying causes were untouched.

As a remedy for this problem, the Center hired an environmentalist, Mr. Andrew James. Mr. James organized the Environmental Health Department. In researching the communities to find the environmental causes of the various diseases listed under environmental causes, the department found an alarming number of environmental factors that breed causative organisms. Among some of their findings were improper or lack of insect controls, improper or lack of waste disposal facilities, impure drinking water, and housing so poorly constructed that sleeping in the open would have been just as healthy. These conditions existed among the poor in both towns and rural areas. It took about five years for the department to solve these problems.

The next problem faced by the new Center was infant mortality. In 1968 the infant mortality rates in Mississippi were for whites 22.7/1000 live births, and for nonwhites 47.8/1000 live births The rates for Bolivar County was shown that year, but certain peculiarities of Bolivar Count's population suggested that the county rates were either more than or equal to the State's rates. Bolivar was and still is rural with over 50 percent black of whom 87.5 percent is below the poverty level.

Assuming that Bolivar County's infant mortality rates were similar to the State of Mississippi rates, infant mortality rates in Bolivar County in 1968 were 22.7/1000 for whites and 47.8/1000 for nonwhites. In 1978 the infant mortality rates for whites in Bolivar County were 15.0/1000 and the rates for nonwhites were 30.2/1000. The differential of 17.6/1000 live births shows the impact the services rendered by Delta Health Center had on infant mortality among blacks.

In 1968, Dr. Florence Halpern, a clinical psychologist, conducted a study under the auspices of the then Tufts Delta Health Center. Dr. Roy E. Brown, a pediatrician and epidemiologist, concerned with the relationship between nutrition and mental development designed the study. The lack of adequate funding prohibited the study being carried out as originally designed. Nevertheless, a cross sectional study was substituted.

A total of four hundred and two black children, ages 36 months and below, were given medical examinations. On the average the black children were somewhat below norms established for white children in regard to anthropometric measurements. They were practically all anemic, some mild, some severe. However, there were no cases of Kwashiorkor or marasmus.

Only 344 children received the psychological test, the Gesell Developmental Scale. The average D.Q. for the 344 children, 175 boys, 169 girls, was 95.98, practically 96, with a range from 50 to 179. Using a D.Q. of 100 as the norm, the children tested very close to the norm, and certainly scored within the normal range.

Testing these children at 3 months intervals, the findings show that at 36 months of age the average D.Q. for the 344 children dropped from 95.98 to the middle 80's.

When the test results were broken down into the four areas defined by Gesell, namely; motor, verbal, adaptive and personal-social; it is the verbal that shows the earliest and severest impairment. Only 23 percent of the children showed a verbal development in line with or above expectancy for their chronological age, whereas in the three other areas close to half of the children score in line with expectancy.

Perhaps most significant of all is the absence of any correlation between the results of the psychological tests and the physical findings. In view of this it was felt that the drop in D.Q. that these children manifest, especially their verbal limitation, are due as much to cultural impoverishment as to nutritional deficit.

Although the evidence above did not prove conclusively that brain damage occurred from malnutrition, other physical evidence point out the children are somewhat underweight and below normal height and that all but ten of them suffer from anemia, constitutes sufficient evidence of their need for nutritional help.

Based on evidence presented in this study and other studies, the project was able to begin a supplemental food program that we believe is the forerunner of the WIC Program.

The forerunner of our present Health Promotion and Disease Prevention Program was the old Community Health Action/Education Program initiated by Dr. John Hatch. The underlying purposes of the program were to present a health care program were to present a health care program to a hardcore population and change their lifestyles.

The program was successful in that it established health councils in communities all over North Bolivar County. Each Health Council rented a building which serviced as a meeting place as well as a place where health education could take place. Immediately after its inception each building became a feeding place for the elderly. The outreach activities of the Health Councils were responsible for much of the success of the old O.E.O. sponsored program.

PREPARED STATEMENT OF STATE REPRESENTATIVE ROBERT G. CLARKE

This report to the Congressional Select Committee on Hunger is rooted in personal research made during personal visits across the district over the past several months. I feel certain that the statistics to substantiate the decline of nutritional standards and to cut back or refuse to increase the basic subsistence allowances have been or will be quoted to the committee members again and again.

For my part I want to express to you the feelings of hopelessness and helplessness relayed to me by citizens I have met time after time in my travels throughout the 22 counties of the Second District. I hope to cause you to feel the same hard knot in your stomach as I did when talking to a young mother of three who had received notice her food stamps would be discontinued for reasons she was unable and unprepared to understand. I really want you to understand how poor parents keep their children home from school because they know the futility of sending them to school to learn on an empty stomach. And, I think you should realize that our feeding programs for the elderly fail to reach those deserving senior citizens who reside in the rural areas of this district which is mostly rural.

This is not a report prepared by a well-meaning staff most of whom have never seen the likes of McClure's Alley here in Greenwood. This is not a presentation for show by folks who have lacked the experience of talking with the people who are subjected to plantation survival in Tunica County. Nor is this a white paper for media consumption prepared by do-gooders who have yet to sense the basic existence of dirt-poor families living outside of Edwards. Rather, this is an expression of one who has personally witnessed these deplorable conditions that are directly affecting my neighbors and friends—my people.

From Tunica County where over one-half of the citizens are eligible for food stamps to Jefferson County where the unemployment rate constantly hovers near 20 percent, too many residents of the Second Congressional District of Mississippi retire at night and awaken each morning undernourished or just down right hungry.

Studies, research and on-site inspection such as you are conducting today have been held in areas of this state dating back to the early sixties. After each study is complete the reaction is usually the same. Some journalist may receive an award for reporting the findings. Some programs aimed at helping to alleviate the situation will be hastily put into place only to gradually fade into oblivion. Many churches and civic-minded organizations will begin food programs. Measures such as these are good. However, they are only stop-gap approaches. They are no more than Band-Aids trying to cover severe hemorrhages.

The long-range, systematic programs to eliminate the conditions must be such as those that followed the Kennedy study here in the sixties. For it was this kind of pervasive effort that allowed our people to see a ray of light at the end of the tunnel. Hope, yes—but much more than hope. The Food Stamp Program, School Breakfast and Lunch Programs, the Women, Infant and Children (WIC) Program and other moves towards nutritional well being allowed Mississippians for the first time in this century to move from the top of the infant mortality rate in this nation, only to move back to the top this year.

Like people throughout this nation the hopes and dreams of an improved society lies in our children. If they are allowed to become nonproductive because they lack the basic necessities, such as a well-balanced meal, then where is our hope. When the dreams of progress are deferred to hunger how can we realistically be expected to pull up by our bootstraps.

The members of this select Committee on hunger will tour some of the truly "blighted" areas of this district today. I ask you to really look around as you inspect. I ask you to understand that when subsistence runs out on the third week of the month that it becomes difficult to look your children in the eye during the final week. I ask you to realize that every time a child misses a day at school for reasons due only to a lack of proper nutrition we all suffer.

As I have travelled from county to county in this district time and again I am approached to help a citizen with some personal problem. But I can unequivocally state here and now that no request for assistance can spur one to action more than to walk into a home where an empty refrigerator is surrounded by a hungry or undernourished family. Like the Physicians' Task Force on Hunger in America I too think your findings will call for immediate action to improve our situation here.

ACCESSIBILITY AND EFFECTIVENESS OF ANTI-HUNGER PROGRAMS

MONDAY, JULY 23, 1984

House of Representatives,
Select Committee on Hunger,
San Francisco, CA.

The committee met at 9:45 a.m. in the Glide Memorial United Methodist Church, San Francisco, CA, Hon. Mickey Leland, chairman of the committee, presiding.

Members present: Representatives Panetta, Fazio, Burton, Roukema, Emerson, and Morrison.

OPENING STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

The Chairman. We're going to begin now. Let me just wish everybody a good morning. I am Congressman Mickey Leland, chairman of the House Select Committee on Hunger.

I would like to thank our committee member, Representative Sala Burton from San Francisco, who represents this area, for hosting our hearing here today. Mrs. Burton was instrumental in identifying San Francisco as a committee field hearing site and for that we are all pleased. We are happy to be here in your town, Sala. Thank you very much for inviting us here.

I'd like to also thank Reverend Williams for making Glide Memorial available to the committee. You've heard about him, you've heard about his work. And we're proud to say that he is among those of us who are most concerned about hunger in America.

We want to thank you personally, Reverend Williams—we know that your schedule is very busy—for facilitating this opportunity for us. You are very gracious, and we thank you very much.

Almost two decades ago, the Federal Government started a system of measuring poverty in America. Strong emphasis in the determining formula was placed on how much money it took to purchase a nutritionally adequate diet at the lowest cost. So, from the start, the measurement of poverty has been linked to what is required to provide the least expensive diet necessary for good health.

Since the late 1970's, more and more people in our country have been falling into poverty. These people do not have the resources to meet basic human needs such as the need for adequate food. In short, many of these people are hungry. The latest available statistics report that 34.4 million Americans live in poverty. A startling

32 percent of the elderly, 21.3 percent of all children, and 15 percent of our total population live in poverty.

The brutal force of poverty and poverty-related hunger knows no prejudice. It strikes members of all races and ages. It strikes in cities and rural areas alike. This committee is concerned about hunger and poverty. We are looking at food and other assistance programs which make up the basic standard of living for this country's millions of people who live in poverty.

Are these programs coming together in a way that meets the goal of assuring every American access to a sound, nutritious diet? That is the goal of these programs. We want your input in reforming these programs to meet that goal.

Last month, the committee visited Greenwood, MS, to investigate poverty and hunger in a rural region of the country. As a result of the testimony we heard, I left Mississippi more knowledgeable of the problems faced by those living in rural poverty. I left Mississippi aware of possible reforms in our programs which would make them more responsive to the needs of participants.

Today, in San Francisco, we have come to investigate hunger in an urban community. I am confident that our witnesses will offer statements and recommendations which will aid us in our effort to end hunger in American cities.

I want to thank you for your participation.

I would like now, if I may, to yield to the ranking minority member of this select committee, Marge Roukema.

Marge.

OPENING STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mrs. ROUKEMA. Thank you, Mr. Chairman. And I want to thank Congresswoman Burton for this wonderful opportunity to visit San Francisco, everyone's favorite city as she keeps reminding me. I'm from New Jersey, but it's a pleasure to be here today on the other side of the continent.

We are here today to hear how the spectre of hunger affects urban areas. And we're also here to learn how well our current programs are doing the job to combat the problem and how they are working. Are they meeting their intended purposes? Should there be some changes? What has been overworked and what is working well?

I call my interest on this committee and its activities the purpose of answering the question of why we continue to have the paradox of hunger in a land of plenty. Now, the paradox is an interesting one. One of the major questions to be examined here today—and it is a paradox—is: Why does hunger persist while we, as a nation, continue to produce more and spend more on food assistance?

At all levels of government, the benefits of our national bounty and invention are made available to the hungry and the homeless. How effectively we are doing this is one of the topics that our witnesses are going to address today.

However, lest we forget the magnitude of our Federal Government's efforts in this area, I would like to point out that in 1983—and I believe this is a startling figure—the Federal Government distributed almost $20 billion in food assistance in one way or another. And that is up from $14 billion in 1980. This is not an insignificant sum. It covers a wide ranging number of programs of aid that affect all elements of our society. And yet, from what we have seen, both in Greenwood, MS and what we know about the problems here in San Francisco, it is a paradox. Despite that number we are not able to get ahead of the problem.

So, our purpose here, again, in visiting the WIC Program earlier today and hearing our testimony, is to find out what is working and how we can better distribute the resources that we now have and where we should be putting additional effort.

Thank you very much, Mr. Chairman. I ask unanimous consent to include the full text of my statement.

The CHAIRMAN. Without objection.

[The prepared statement of Mrs. Roukema appears at the conclusion of the hearing, see p. 185.]

The CHAIRMAN. The Chair would like to now recognize Sala Burton. Sala.

OPENING STATEMENT OF HON. SALA BURTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. BURTON. Mr. Chairman, Mrs. Roukema, I'm very pleased that you are here in our beautiful city of San Francisco. I am most grateful to you for bringing your committee here.

I also want to thank my dear friend, the Reverend Cecil Williams, who has dedicated his life to eradicating hunger in this city. Today is the day we are going to see and hear what it is we can do in order to erradicate hunger in America. Thank you again for coming here.

The CHAIRMAN. Thank you.

[The prepared statement of Mrs. Burton appears at the conclusion of the hearing, see p. 186.]

The CHAIRMAN. The Chair would now like to recognize the chairperson of the task force for the Select Committee on Domestic Hunger. He is no newcomer to this area. He is the chairman of the Subcommittee on Domestic Marketing, Consumer Relations, and Nutrition of the Agricultural Committee, a dear friend and one who has devoted his life to trying to end hunger, particularly in America.

I would now like to yield to the chairman, for the purpose of conducting this hearing, of the Task Force on Domestic Hunger, Leon Panetta from California.

OPENING STATEMENT OF HON. LEON E. PANETTA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. PANETTA [presiding]. Thank you very much, Mr. Chairman.

And thank you, Sala, for giving us the opportunity to be able to hold a hearing here in San Francisco. Last week Democrats gathered here in the euphoria of the convention. This week, on a bipartisan basis, we return to the realities of life to talk about the problems that face all of us in this country.

I have the privilege of chairing not only the Task Force on Domestic Hunger but also the Subcommittee on Nutrition of the Agricultural Committee, that has jurisdiction over many of the issues that we deal with. We have learned throughout our investigations that this Nation has to act effectively to deal with hunger, because hunger is a problem that impacts on not just those that are affected by it but all of us because it impacts on our society. And for that reason it is important for us to address the problem of malnutrition in our society.

During the last 2 years, we've taken steps to try to deal with it, by introducing bills to deal with the distribution of commodities, to try and improve programs that provide assistance to the hungry. This week, as a matter of fact, Bill Emerson, who is the ranking minority member, and myself, have introduced the Hunger Relief Act of 1984 which is expected to be on the floor of the Congress this week and which tries to provide general assistance to those who need it. And it is our hope that this week can end, hopefully, by having the Congress—at least the House—take a step in that direction.

We've looked at problems of world hunger and we have an opportunity, today, to look at the problem of urban hunger. Whatever hunger we're looking at, it's a national shame in this country that we're looking at hunger at all. And, so, the purpose of this subcommittee and the purpose of this task force is to try to effectively respond to this problem and try to end huger once and for all in our society.

The Chair now recognizes the gentleman from Missouri, Mr. Emerson.

OPENING STATEMENT OF HON. BILL EMERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. EMERSON. Thank you, Mr. Chairman. I think, in the interest of time, I would just ask unanimous consent to insert my opening statement in the record.

I do want to take this opportunity to thank Mrs. Burton for her hospitality in having us in her district. We're delighted to be here in San Francisco. I think we should go on and hear what the witnesses have to say.

Mr. PANETTA. Without objection the gentleman's statement will be made a part of the record.

[The prepared statement of Mr. Emerson appears at the conclusion of the hearing, see p. 186.]

Mr. PANETTA. Mr. Fazio.

OPENING STATEMENT OF HON. VIC FAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FAZIO. Mr. Chairman, I have no statement at this time. I would simply like to indicate that it is a great pleasure for me to come down Highway 80 through the Sacramento Valley and to be present here at the Glide Memorial Church that I've heard so much about. Thank you very much.

Mr. PANETTA. The gentleman from Washington, Mr. Morrison.

OPENING STATEMENT OF HON. SID MORRISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. MORRISON. Thank you, Mr. Chairman. I would like to add my voice in appreciation to those who have put together the meeting and to Mrs. Burton and her thoughtfulness in making us feel very comfortable here in a city that seems like home to so many across America.

Let's include Reverend Williams for the opportunity to be in this famous spot. It is a place that you have made so important to many Americans. Thank you.

Mr. PANETTA. The first panel of witnesses will be testifying on the effectiveness of Federal food and related public assistance programs. The panel is comprised of the following: Jan Hartsough, who is the chairperson for Mayor Feinstein's task force on food and hunger, and Ms. Zoraina James-Harris, who is Mayor Feinstein's program manager; Ms. Judy Shutzman with the San Francisco County Welfare Department, Mr. Sam Karp, administrator of food and nutrition services from Santa Cruz, CA.

Ms. Hartsough, you may proceed with your testimony. Or, Ms. James-Harris, you may proceed with your testimony.

STATEMENT OF ZORAINA M. JAMES-HARRIS, ADMINISTRATIVE ASSISTANT, SOCIAL WELFARE PROGRAMS, ON BEHALF OF DIANNE FEINSTEIN, MAYOR OF SAN FRANCISCO

Ms. JAMES-HARRIS. Thank you very kindly. My name is Zoraina James-Harris, and I'm here today representing Mayor Dianne Feinstein, who is, regrettably, unavailable, but thought it essential that her deep and abiding concern about the issue of hunger be recorded with your august body.

As a result of growing national concern about the prevalence of incidences of widespread hunger throughout the Nation, Mayor Feinstein convened a task force to determine the existence of hunger in San Francisco, in March 1984. Wanting to learn the impact of Federal-domestic budget cuts on feeding programs for mothers, children, the homeless, unemployed, seniors and disabled, the mayor gave the Task Force on Food and Hunger the following mandates: To assess the needs, define "data and services," list recommendations, and develop strategies for implementing the recommendations.

The mayor's Task Force for Food and Hunger found that it has become increasingly difficult for agencies to serve more with less, and that they have not been able to meet the demands of San Francisco residents with existing resources. Government programs are helpful but fail to equal the increasing needs.

The Task Force on Food and Hunger has a preliminary draft of the report to present to you. Jan Hartsough, who chairs the mayor's Task Force for Food and Hunger, will provide a detailed presentation on the reports.

I must emphasize that the report is preliminary. The task force is now in the process of making the recommendations known to the mayor. I ask that the record be kept open for the final draft of the report. I think that the recommendations will be of interest to the committee. Thank you.

Mr. **Panetta.** Without objection we will keep the record open for that report.

Responses to Questions for Zoraina M. James-Harris

QUESTIONS SUBMITTED BY HON. MARGE ROUKEMA

Question. What is San Francisco's unemployment rate now? What was it a year ago? In 1980?

Answer. The following information was received from the Employment Data and Research Office of the State Employment Development Department. The method of compiling these statistics is in accordance with guidelines of the department.

ANNUAL AVERAGE UNEMPLOYMENT RATES FOR SAN FRANCISCO

	1980	1981	1982	1983	1984
Percentage	6.3	6.7	8.5	8.7	NA
Number	21,800	24,000	30,900	32,400	NA

Question. Please describe briefly San Francisco's financial situation. Is there a surplus in the budget this year? What was the situation a year ago? In 1980?

Answer. The 1984-85 budget is fully funded and there is a small surplus remaining. Although there were newpaper reports of a large surplus during June 1984, much of this money was required in advance to balance the 1984-85 fiscal year plan. In excess of $2,090,000 of the surplus has been used to meet the shelter and food needs of the large homeless population in programs sponsored by the city. One year ago, in the 1983-84 fiscal year, our situation was much the same. We began the fiscal year with a small surplus, yet managed to provide fundings for food and shelter to the homeless. It was in the 1982-83 fiscal year that we initially observed the tremendous influx of homeless and had to respond to this human and economic crisis. In 1980, our fiscal position was much less secure. We were hard pressed to balance our annual budget.

Question. How will the mayor utilize the report of the Task Force on Food and Hunger? What kind of followup is planned? Will resources be committed to carry out its recommendations?

Answer. Mayor Feinstein will utilize the information contained in the report as an assessement of the state of hunger in San Francisco and as knowledge of existing, available resources. In addition, Mayor Feinstein will review recommendations with the understanding that the recommendations will be directed at the local, State, and Federal government for implementation. Moreover, there will also be the perception that some of the recommendations may appropriately be implemented by the private and corporate sector. There may also be recommendations which cannot be implemented.

After Mayor Feinstein has identified the recommendations which she wishes to have implemented, the Food and Hunger Task Force will seek to fulfill those mandates. Resources will continue to be committed to feed the hungry at the local level.

It is hoped that other levels of government will also respond favorably to identified food needs.

[The report referred to above appears at the conclusion of the hearing, see p. 213.]

Mr. **Panetta.** I would like to remind you, if you could, to keep your statements under roughly 5 minutes, because we're on a tight timeframe. That gives us time for questions as well. But if you could, keep your statements around that vicinity.

Ms. Hartsough.

STATEMENT OF JAN HARTSOUGH, PROGRAM ASSOCIATE, AMERICAN FRIENDS SERVICE COMMITTEE, ON BEHALF OF MAYOR'S TASK FORCE ON FOOD AND HUNGER, SAN FRANCISCO

Ms. **Hartsough.** Thank you.

I work for the American Friends Service Committee here in San Francisco, both as an educator and an advocate on food issues, and also as an organizer of direct marketing and other food alternatives.

Perhaps you saw, yesterday, our heart of the city, Farmers Market, which is just a few blocks from here on the edge of the Tenderloin, which is an opportunity for 30 or more farmers to come to the city and sell directly to inner city residents. That was something we organized a few years ago.

As chairperson of the mayor's task force on food and hunger, I want to share with you some of our preliminary findings. But first, I want to tell you who is on the task force, many of whom are here in the audience to answer specific questions that you might have about certain kinds of programs that they work with.

We have representatives of both public and privately funded food programs. We have all age groups: programs serving children, programs serving the elderly, programs dealing with emergency assistance, soup kitchens, a wide range. And we have listened to testimony on all kinds of programs, and the problems that exist within those programs. And that is what I want to share with you now.

The combined impact of budget reductions in all Federal aid programs, from food to shelter to income assistance, has reduced the ability of low-income people to meet their most basic survival needs. California has lost a total of $9.5 billion in Federal aid since 1981, an amount equal to $383 per person in the State. In San Francisco, where the fixed costs of living are high, food is often the most optional item. Dwindling Federal food assistance, chronic unemployment and underemployment, and the high cost of living, translates into a dramatic increase in the need for local emergency food assistance.

Many agencies are delivering assistance to the maximum capacity of their resources, both human resources—time and energy—and material resources—buildings and equipment that they have to work with. Existing emergency meal programs are under funded and, therefore, unable to adequately meet this growing demand. Federal funding for emergency food under the FEMA Program made it possible for many programs to temporarily address the food needs of those who were cut out of established programs. But the abrupt ending of the FEMA Program left agencies here without resources to sustain this increased demand. The temporary expansion of emergency food programs did not satisfy the need in San Francisco, but rather served to expose the enormity of the problem.

Evidence that the task force has uncovered is overwhelming and startling. Some of our preliminary observations reveal that requests for emergency food assistance in the city and county of San Francisco has more than doubled over the last year:

The St. Vincent de Paul Society reported that in 1980 they were serving 4,000 meals per month, and currently they serve about 25,000 monthly.

The Glide Community Food Program, right here, serves three meals each day of the year to 3,000 people, yet turns hungry people away every day.

Self-Help for the Elderly in Chinatown serves hot meals to 4,000 seniors each week. And frail seniors must wait in long lines in order to reserve their next day's meal, and still many are turned away.

In 1983, the San Francisco Food Bank was distributing 20,000 pounds of food each month. Currently, they are distributing about 100,000 pounds of food every month.

The Summer Food Service Program, here, distributed 250,000 free lunches to needy children last summer, which is 50,000 more than the year before.

That is just to give you some idea of the increasing demand right here in our city.

We also found that the nature of those relying on public food distribution has changed. Many are now from families suffering the effects of long-term unemployment, high rents, and reduction in Federal aid. And I read in the paper, just yesterday, that between 1980 and 1983, in the bay area, 303 plants have closed down with about 33,000 jobs lost here in the bay area. So, that is some of the background for the families that we're now seeing here in San Francisco in food lines:

Eighty-five percent of the food boxes that are given away through our Emergency Food Box Program are going to women with children.

St. Anthony's Dining Room, just down the street, reports that more and more children come to their meal programs at noontime, which means those children are not in school, that they have nowhere else to go to get a meal.

Glide Community Food Program was forced to cut back services to singles in order to serve the growing number of households with children, and have developed a childrens program, which I'm sure you've heard about.

Childcare centers throughout the city report that children are coming to their centers hungry, and yet the available food has been severely cut back. And school meal participation is down while school enrollment in San Francisco is up.

So, again, we see not the typical person that used to be the stereotype of who is hungry and who is looking for food assistance, but we see, especially, many more women and children. Also, despite the extraordinary efforts of both public and private groups in San Francisco to meet the growing demand for food, it is very clear to us on the task force that the need is not being met. For instance:

The San Francisco Supplemental Food Program for Women, Infants, and Children, the WIC program, is only able to serve 23 percent of those eligible for it benefits here in the city.

Emergency food providers are forced to turn people away because they either do not have enough food to distribute or they have inadequate facilities to store and prepare food.

Most of the over 10,000 seniors in the city's Tenderloin area right here live in a single room occupancy hotel with no means of storing or preparing their food, and often use illegal hot plates with the ever present danger of fire.

Homebound, elderly, and disabled people remain on waiting lists to receive home-delivered meals.

The release of the chronically mentally disabled from institutions without adequate community support services has added a permanent demand to the already strained resources of both publicly supported and voluntary feeding programs. And I think you'll be hearing more about that from Glide.

The immigrant, refugee, and undocumented populations remain outside most food service programs because of language difficulties, cultural prohibitions, confusion and fear of deportation. And for us here in San Francisco, as you probably know, we have a very large immigrant and refugee population; so that this is another very serious concern—how do we serve that group of people?

USDA commodities are sporadic, do not meet the nutritional needs of most adults, and are often detrimental to the health of special populations.

As service providers in this land of abundance, we feel that it is an unbelievable paradox that increasing numbers of hungry people wait in food lines while 20 percent of all food produced in our country is wasted before it ever reaches the consumer. We need to examine how the food industry contributes to the problem of hunger, and we must look at how our governmental policies can better work to protect the needs of the consumer as well as those of industry.

The 4-mile long caves that hold the USDA surplus cheese and butter at considerable expense are one example of the subsidy programs and policies that the Federal Government promotes to artificially support the food industry. Paying farmers not to farm their land and then giving them surpluses of the same crops that they would have produced to sell for profit in the market place—the PIK Program is another. Allowing orange growers to plow under bumper harvests of smaller than standard sized fruit, these kinds of things disturb us as people who are trying to get food to those who really need it, yet we know food is being wasted.

We feel strongly that hunger is due to poverty and the inequitable distribution of resources, and not just inadequate supplies of food. Equal access to employment opportunities and fair wages is the only way to alleviate hunger in our communities. If people had adequate income to meet their fixed costs of rent, utilities, and health care and still have enough left over to purchase nutritious food, then we could have justice. Until such opportunities exist, the need for Government and privately sponsored food programs remains paramount.

The task force has looked, as I said, at a broad spectrum of programs, over 100 in all here in the city, and we offer the following recommendations. And I will just highlight some of the ones that relate to Federal programs, but we have others that are local, either State or here in San Francisco.

For seniors and adult disabled we very much feel the need to upgrade or expand existing facilities, equipment, staffing, operating costs and number of meals for congregate and home delivered nutrition programs, and we'd like to see an increase in the title III C-102 moneys that come to San Francisco. I think we do an excellent job, but we need more money than we have.

We want to expand existing home delivered meal programs and extend these programs to the adult disabled under 60 years of age.

That is another strong concern that we have, is that those over 60, at least there are some programs meeting their needs, but the disabled person under 60 has very little available to them.

And we also would like to see an increase in HUD funding to assure that new and rehabilitated senior residences have congregate meal space with allowances for the development of central kitchens, because of waiting lists for senior meals. If there is no such provision to have a meal program at the new HUDs that are going up then we're right back where we started with people waiting in line.

And we would also like to enact legislation to establish a commodities supplemental food program in San Francisco to provide nutritious monthly food packets for senior citizens. We do have some excellent commodities programs here, but not specifically for seniors at this point in time.

On food stamps we're concerned that the allotment needs to be increased. I'm sure you have heard everywhere you go, and in the studies that all of us have read in the past year, that people run out of money before the end of the month. And it seems fairly obvious to us that the allotment needs to be increased. But the basis upon which that allocation is made, the Thrifty Food Plan, seems to us neither economically nor nutritionally adequate.

And we have some concerns in respect to the pilot programs, some of which are being tried here in San Francisco, and are asking the mayor to set up a local committee to study some of the implementation problems with them.

In childcare programs we've talked a lot on the task force of school meals and summer food programs. And child care centers, day care homes, all of these programs, need more money in order to provide adequate food.

As I'm sure you know, funding has been cut so that in child care programs they no longer have three meals and two snacks. We would like to see that money brought back so that there can be an adequate food for children in child care centers.

And there is also concern in San Francisco on all age levels to take into account the ethnic diversity of the city in the meals that we have, because this is a serious problem. There are things in just the general American food plan that are not applicable to our ethnic population, and there are also many health related problems, both of children and of seniors, that aren't addressed by this sort of standard food menu. Diversity is possible.

There is also concern to simplify the paper-work requirements in terms of the redtape in all Government programs. This goes back to food stamps, too. Some of the dropouts from the system, I think, are people that can no longer cope with all of the different kinds of reporting that's being asked of them.

And for the WIC Program, as you've had an opportunity to see this morning, we feel that we're doing an excellent job with WIC here; but the need is to double the program, because there are many people that are not on it simply because we can't enroll any more at this time.

We have spent a fair amount of time on the task force looking at nutrition, education and advocacy. And I know there is some proposed legislation already before you, but we would like to encourage the establishment of an ongoing nutritional assessment system on a national basis, that takes into account the multi-ethnic composition in our country. And this is especially true—we're asking this for San Francisco too, knowing—that we have inadequate information as far as being able to compare across-the-board the different groups in the population.

And we feel that it is very important to fund nutrition education component in all food programs, and that is nutrition education both for the provider and, also, for the recipient. That is a crying need that we don't have. Many of us, even our teachers and others whom we think should know about nutrition education, often do not have any formal training at all.

For emergency food programs, which are a major portion of what goes on here in San Francisco, the FEMA money was very helpful and we'd like to see the FEMA Program brought back to help us meet the growing need for emergency food services. And in addition to FEMA, we need help in developing some kind of ongoing funding for emergency food resources. And I think that is probably local, State, and Federal, wherever it can come from.

One possibility is to restore administrative funds from the 2.8 percent to 5 percent from the State Department of Education for USDA commodity distribution statewide.

And last, the other food access arenas—which is really my field—I think an important thing that ties in with health care is the need for quality available, affordable dental services for low-income people in this country. We're talking about people needing food in order to live a healthy life, but there are many people who can't even eat the food that might come their way because of such extreme dental problems; and dental care is not very accessible, at least in this city.

We would like to promote experimentation in terms of single room occupant hotels—some kind of safe legal hotplates; some way of storing; of having refrigeration; perhaps communal kitchens—various options for people so that we're not steering them always to an emergency meal or a congregate meal. A lot of people would like to take care of their own food needs. And yet, in a hotel with no cooking or storage facilities, how can they do that?

We would like to promote community gardening and gleaning programs in San Francisco, and better transportation and delivery systems; and, in general, to increase access to affordable food, such as the Farmer's Market that I mentioned, and food buying clubs. One creative thing that is going is vending machines in some of the single room occupancy hotels, where people can get healthy choices in a vending machine in their own lobby rather than having to go out.

Those are some of the highlights that we're finding.

Thank you.

Mr. PANETTA. Thank you very much.

RESPONSES TO QUESTIONS FOR JAN HARTSOUGH

QUESTION SUBMITTED BY HON. VIC FAZIO

Question. In your testimony you made reference to the manpower necessary to carry out a smoothly run commodity distribution program. Would you detail the manpower problems you have been encountering?

Answer. No response received.

QUESTION SUBMITTED BY HON. BILL EMERSON

Question. There are many Federal programs available for people in need here in San Francisco and across the United States. Can you tell us what special State or county programs may be available. Have they, like the Federal programs, grown in the number of people served and money spent as the Federal programs? Please be specific. Any general relief, or emergency aid programs.

Answer. No response received.

Question. Many mayors have set up hunger commissions to ensure that the needs of their citizens are evaluated and met through both Government programs and volunteer efforts. Can you describe the one which you serve?

Answer. No response received.

Question. From your perspective is San Francisco different from other cities or counties in California with regard to living conditions or benefits available for the needy? Is it worse, better, the same as some neighboring counties?

Answer. No response received.

Question. Have conditions worsened over the past years? Can you compare conditions with a period of 10 years ago or 5 years ago?

Answer. No response received.

QUESTION SUBMITTED BY HON. SID MORRISON

Question. On page 2 of your statement, you state: "California has lost a total of $9.5 billion in Federal aid since 1981. . . ." Would you please explain what you mean by the term lost? How did you arrive at this figure?

Answer. No response received.

Mr. PANETTA. Ms. Schutzman.

STATEMENT OF JUDITH A. SCHUTZMAN, EXECUTIVE ASSISTANT, SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES, ON BEHALF OF EDWIN S. SARSFIELD, GENERAL MANAGER

Ms. SCHUTZMAN. Thank you for the opportunity to speak to you today. I am Judy Schutzman, executive assistant to the general manager of the San Francisco Department of Social Services.

Our department is responsible for administering of all public assistance programs in San Francisco, including: Aid to Families of Dependent Children, general assistance, refugee resettlement, Medi-Cal—which is the State's medicaid program—food stamps, and social services for children and adults.

The department is headed by a general manager who reports to a five-member policymaking commission which is appointed by the mayor. Our budget is $183 million this year, of which $116 million is direct cash payments to recipients. An additional $18 million in food stamps and $25 million in Medi-Cal payments is provided each year to San Francisco residents. Except for general assistance, all programs are mandated by Federal law and receive Federal and/or State funding. General assistance is required by state law but is wholly county funded.

I would like to focus on three of these programs: AFDC, general assistance, and food stamps.

The AFDC Program provides financial assistance, food stamps and medi-cal benefits to families, providing what they need as a result of deprivation of parental support or care. The program has two components: Family groups and unemployed parent.

Family groups comprise the largest segment of the program with 10,300 families who are in need as a result of the incapacity, absence or death of either parent. A large majority—93 percent—of these families are headed by a female and average two children.

The unemployed parent group includes two-parent, intact families who are needy because of the unemployment of a parent living in the home. Approximately 2,500 families fall into this category. Although case load has stabilized in the past several months, this program has experienced an 82.5 increase since mid-1980.

Benefit levels for the AFDC Program are set by State law as part of the budget act. Effective July 1, 1984, a typical family of three with no other income receives a maximum payment of $555 a month. Expenditures for cash assistance in this program will total $75 million this fiscal year in San Francisco. Funding is at a ratio of 50 percent Federal, 45 percent State, and 5 percent county. All recipients are covered by Medi-Cal and approximately 77 percent receive food stamps.

The high cost of housing in San Francisco is a critical issue for AFDC recipients. While landlords cannot refuse to rent to families with children, the cost of a residence large enough to accommodate a family often exceeds the total monthly grant level for all the basic necessities of life. Proposition 41 on the November State ballot, which calls for 60 percent reduction in AFDC benefit levels, will make it impossible for a poor family to reside in San Francisco or, in fact, in any urban area in California.

The General Assistance Program is the program of last resort for those who do not qualify for any other categorical aid. It is designed to provide short-term cash or in-kind assistance to indigent persons who are unemployed or disabled. Persons who are able-bodied are required to participate in a work program and to actively seek employment. The disabled must participate in a treatment program designed to alleviate their disability, if it is temporary, or to apply for Federal SSI benefits if it is permanent. Most recipients are single adults between the ages of 18 and 64 years.

Although mandated by State welfare and institutions code, the GA Program is wholly county funded and operates under the authority of local ordinance. The board of supervisors establishes eligibility criteria and sets the grant level. Currently, the payment level per month is the same as for AFDC at $272 per month for a single individual. 95 percent of recipients also receive food stamps but have not been eligible for Medi-Cal since January of 1983.

The general assistance caseload in San Francisco has grown dramatically in the past 3 years. From a low of 3,700 in January 1981, we now have over 8,200 clients. There has also been a shift in the type of clients from primarily young—mid-20's—employable people to primarily middle-aged—35 to 50—disabled persons.

Our SSI pending case load peaked at 2,200 and has just started to decline as our efforts at advocacy were increased. Disability on the basis of mental illness required the department to add a psychologist to its medical review team this year. The homeless have also contributed greatly to the growth of the GA Program. Since efforts to house the homeless in large numbers began during the disastrous rains of the winter of 1982, the case load has grown by over 2,000. San Francisco has approximately 3 percent of the population of the State, but pays out nearly 13 percent of State-wide GA payments and carries nearly 10 percent of the case load.

As part of several changes made to the general assistance ordinance in 1981, the department instituted an in-kind assistance program which provides housing and meals in lieu of cash payments during the first 2 weeks of eligibility. Hotel rooms at a considerably reduced cost over the market rate house nearly 900 people per night, and a congregate feeding site here at Glide feeds 800 of our clients three meals per day 7 days a week.

Like AFDC recipients, housing is a critical issue for GA clients. Rents at single room occupancy hotels in San Francisco typically rent for $200 to $240 per month, leaving little of the grant left over for food, clothing, laundry, transportation, and other necessities.

The Food Stamp Program serves nearly 22,000 households per month in San Francisco with an average monthly benefit of $75.86 per household. The program is divided between those receiving public assistance—all AFDC recipients basically—and those who receive only food stamps. Each month 46,000 persons receive benefits. While this sounds like a large number, in 1981 we were serving 52,000 people. Because California is a cash-out State, nearly 32,000 SSI recipients who would otherwise qualify do not receive food stamp benefits. Of those who are certified eligible, 97 percent participate in the program.

In September 1983, San Francisco served as the pilot county for development of an online issuance system called FAIR. This program permits direct data entry of eligibility and benefit information to the outlets which dispense food stamp coupons. The client no longer receives a monthly authorization to participate card in the mail, but instead receives a magnetically encoded plastic card which is valid for the entire term of eligibility. This new system has totally eliminated duplicate issuance of benefits and has resulted in economies in the establishment of eligibility, postage, bookkeeping, and reconciliation. Combined with staggered issuance of benefits over the first 10 days of the month, which began in August, savings have also been realized in issuance costs.

The Food Stamp Program has experienced a great deal of uncertainty and flux over the past year as a result of frequent changes in regulations, many of which both workers and clients find illogical and difficult to deal with.

I will be happy to answer any questions.

Mr. PANETTA. Thank you very much.

RESPONSES TO QUESTIONS FOR JUDITH A. SCHUTZMAN

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Can you provide information for us on the time it takes between the application for and the actual receipt of food stamp benefits in your county—both for normal and expedited services?

Answer. Under food stamp regulations the county has 30 days to process normal applications and 5 days to process requests for expedited services. Typically, San Francisco sees over 1,900 applicants per month of which 75 percent request expedited services.

A normal applicant results in benefit receipt within 20 days. Expedited services applications are disposed of and benefits delivered within 3 days. In July 1984 the department had a total of 27 applications pending over 30 days out of a total 1,300 received.

Question. How has the new insurance system affected processing time for applicants?

Answer. The new issuance system has not affected processing time for normal applications. It, along with an increase in the numbers of applicants, had resulted in a delay of 1 day of for those requesting expedited services.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. How many people receive food stamps here in San Francisco County? Do most of these families also receive help from other programs, such as AFDC, Summer Feeding, Head Start and other programs. Please be specific.

Answer. In San Francisco, 46,000 persons per month receive food stamps. Of the total 21,800 certified households 9,500 also receive AFDC and 6,600 receive general assistance. These two groups account for approximately 33,300 persons. Since we do not administer Summer Feeding, Head Start or other programs we do not know how many families also receive such help. We do send mailings each year to all AFDC recipients informing them of their eligibility to Summer Feeding and Head Start Programs.

Question. Do you take different applications and apply different rules for the same family for different types of assistance—such as food stamps, AFDC, child care, title XX benefits? What can be done about this?

Answer. Yes. The department must take separate applications and apply separate eligibility criteria for each financial assistance program it administers. Income and asset limitations vary from program to program so that not every AFDC family is eligible to receive food stamps by virtue of net income in excess of food stamp standards. In fact, only 72 percent of AFDC families receive food stamps.

Most service programs under the title XX umbrella are provided without regard to income since they involve services which are designed to protect children and the aged, blind and disabled from abuse, neglect or exploitation.

Achieving uniformity in rules for the various programs is impossible so long as there are three levels of authority involved in the administration of welfare. Federal law is frequently supplemented by State laws and regulations which take into account the demographic and economic variances existing within California. With California, each of the 58 counties adopts different rules regarding general assistance payments under State law requiring county support indigents.

Some solutions include:

1. Federalization of all welfare programs in a manner similar to the SSI Program;
2. A Federal task force which would examine the various entitlement programs for uniformity of means tests; and
3. Simplified regulations for the programs including universal application forms and clear-cut, not-contraditory rules which permit consistency of application.

Question. Is your office involved in the surplus commodity distribution program? Please describe it.

Answer. The Department of Social Services is not involved in surplus commodity distribution. This program is coordinated through the mayor's office

Question. Does your agency operate any nutrition education programs for low-income families? If so, please describe them.

Answer. No, these programs are operated through the Department of Public Health.

Mr. PANETTA. Mr. Karp.

STATEMENT OF SAM KARP, ADMINISTRATOR, FOOD AND NUTRITION SERVICES, INC., REPRESENTING THE NORTHERN CALIFORNIA ANTI-HUNGER COALITION

Mr. KARP. Good morning, Mr. Panetta, and ranking member Congresswoman Roukema, and other members of the Select Committee on Hunger. My name is Sam Karp. I work at providing adequate nutrition, transportation, and health programs in Santa Cruz, San Benito, and northern Monterey counties here on the Central California coast. And I am here today representing the Northern California Anti-Hunger Coalition.

Thirty-eight years ago Maj. Gen. Lewis Lane Hershey testified before Congress—he was then Director of the Selective Service System—that 70 percent of the men who had been rejected from the draft during the Second World War suffered from malnutrition as children. Congress responded to General Hershey and others by enacting the National School Lunch Program. And I quote from that enabling legislation—enacted "school lunch as a measure of national security." Today, 38 years later, we have a nutritional crisis that, once again, threatens the national security of this country. And unless we are prepared to act quickly and decisively, I fear that hunger will rapidly become another American institution.

Hunger is not a new phenomenon in America, but what is most frustrating about its resurgence is that it is a problem we know how to solve but don't. It has been said that a measure of society is how well we treat our children and our elders. Today, children are the poorest age group in America. They are most likely to suffer sickness and death, hunger and cold, abuse and neglect. One out of five American children are poor, one out of two black children are poor, two out of five Hispanic children are poor. Our elderly live with the fear of becoming warehouse institutions rather than living out their years in a home and community environment with the respect and dignity that they deserve. And the cost of illness is becoming the highest price that Americans pay.

This hearing today does represent a step forward. After a solid year of hearings and countless testimonies we have finally moved beyond the questionable existence of hunger, and we can now get on with doing something about it. I have been asked to provide you with an overview of the national nutrition programs and to discuss the inadequacy of the benefit levels and the effects of the various regulatory changes and budget reductions. I submitted to you a longer and more detailed text, but will be happy to answer any questions about what I've written or what I say now.

I will begin by talking about the national nutrition programs.

There are two programs which address special needs of America's elderly: Congregate meals and home delivery meals. The Congregate Program provides nutritionally value meals and affords opportunities for social interaction and companionship. The Home Delivery Meals Program provides meals to those who are homebound by reason of illness or incapacitating disabilities or who are otherwise isolated.

The level at which funding is appropriated by both of these programs is seriously inadequate. Nationwide, only 9 percent of the eligible population is being served. Here in California, 4,000 senior citizens are turned away from congregate nutrition sites and 9,000 others are on waiting lists to receive home delivery meals.

Participation by minority elderly here in California, as across the Nation, has been steadily declining, and varying restrictions that prohibit equal access must be removed.

We are also experiencing in California a statewide pattern of increasing requests for home delivery meals. We believe that this increase can be attributed, in part, to Federal attempts to contain the rise in hostel costs through medicaid and medicare reform. With the phasing in of hostel payments on the basis of diagnostically related groups—DRG—we are finding an increase in the early release of senior citizens from acute care. Many of these patients, when they get home, are in immediate need of a home-delivered meal during their home convalesence.

The California Department of Aging has estimated that 5,000 elderly Californians are in nursing homes simply because we do not provide for their daily nutritional requirements.

Americans 85 and older make up the fastest growing population group in America. Their numbers are expected to double by the year 2000 and rise even more rapidly in the next century. It is this growing population that an expanded Home Delivery Meals Program would most greatly benefit, and it is our entire society that benefits by the enhanced quality of life for our elderly.

I should mention that after the preparation of this testimony just a few days ago, Gov. George Dukmegian, here in California, signed a $5 million State appropriation, a bill that is sponsored by senior nutrition program directors in California, to wipe out this 9,000-person waiting list and to expand the program from 5 to 7 days a week by special diet and outreach. The state is forced to act because of these growing numbers. It is not solely a State responsibility; the Federal Government must also participate.

Budget cuts in the National School Lunch and Breakfast Programs have forced 650 schools to drop out of the breakfast program and over 2,000 schools to drop the lunch program nationwide. Between 1980 and 1983, 3½ million children, including over 1 million low-income children, no longer receive a school lunch. The School Lunch Program here in California, once a model for the entire Nation, is being dessimated by reduced staff, diminished quality, and variety of meals, and increased meal cost.

Over the last 2 years, 77 million meals have been dropped here in California. This amounts to an average of 425,000 each day, with each meal representing one child. eighty out of 1,100 California public schools have dropped the lunch and breakfast program entirely, because they cannot make ends meet.

Poor children who depend on the School Lunch Program for between 34 and 49 percent of their daily nutritional requirements have little chance to compensate when they don't get a lunch. While we have 90,000 schools nationwide participating in the School Lunch Program, only 33,000 schools offer breakfast programs. In 1980, a GAO study found that the major factor which prevented schools from sponsoring breakfast programs is that the reinbursement rate is too low. New incentives are needed to encourage schools to open breakfast programs. Should we not require that if a school serves 20 percent of free and reduced-price meals that they also be required to operate a breakfast program? For if our future is not our children, I ask, what future do you really have?

The Summer Food Service Program for Children, another federally funded program, is designed to feed children during the summer months when school food services aren't in operation. In 1981, the administration attempted to eliminate the Summer Food Service Program. Again, in 1982, the administration attempted to eliminate it, and in 1983, and in 1984. Fortunately, these attempts failed.

However, the administration was successful in excluding churches, voluntary agencies, and other nonprofit organizations from contracting to provide summer meals. This change alone accounted for a drop in participation nationwide of 500,000 children. In California, during the same period, 14,000 children lost access to summer meals. And here in San Francisco, 62 sites were closed and nearly 6,000 children a day were denied meals.

In fiscal year 1983, summer meals nationwide in California and here in San Francisco are up from the 1982 level, but they are still far below those levels of 1981. We would strongly urge that private, nonprofit sponsors—churches, voluntary organizations—again be permitted to operate and to sponsor this program.

The Childcare Food Program, another important national, Federal program, provides reimbursements to licensed childcare centers and family daycare homes for meals served to children in their care. The need for acceptable, high quality, affordable child care is increasing daily. Over 40 percent of mothers with 1-year-olds work; 57 percent of mothers with children between the ages of 3 and 5 work. The Childcare Food Program helps to make child care affordable for these parents.

A recent California State Department Health Services study found that access to child care was the single most important factor in reducing repeated teenage pregnancies when combined with helping mothers get back into school. The Childcare Food Program also assists parents by requiring that providers of day care be licensed, thereby assuring at least a minimum standard of care.

In fiscal year 1982, funding for the Childcare Food Program nationwide was cut by 30 percent, over $130 million. As a result, 41 percent of California programs have reduced meals and 14 percent have dropped out of the program completely. For many children who spend up to 12 hours a day in a family daycare home or child daycare center, the result has been a reduction of three meals a day to two, and from two nutritious snacks to only one.

Before I continue I want to acknowledge the fact that each of you, all 7 of you members here today, voted to support H.R. 7 and joined with 340 of your other colleagues in a strong bipartisan effort, which will restore the one meal a day and the one snack a day, will add $79 million to the WIC Program, will increase the reinbursement rate for breakfast by 6 cents a meal, to correct and reverse some of these things that have occurred. And I want to acknowledge that you did that, and I want to urge you to do whatever you can in your efforts to set aside what is all so apparent. [Applause.]

I know that earlier this morning you were scheduled to visit a service-delivery site of the WIC Program. And later this morning you will hear compelling testimony from Doctors Costillo and Mendoza. However, I do want to briefly mention the importance of WIC.

Numerous studies and USDA evaluation have made WIC the most studied and conspicuous health program of its kind in America. Despite this improved record of success and wide bipartisan support, the WIC Program still does not have entitlement status. Each year the program must spend within a finite appropriations ceiling and is currently serving less than one-third of the medically at risk eligible population. Here in California WIC serves only 21 percent of those who are eligible.

Again, given the time limitation of this hearing, I cannot begin to do justice to the Food Stamp Program and our concerns. I do, however, want to tell you that the Food Stamp Program has been and continues to be the most effective single program in improving the nutritional standards of low-income families in America. Since 1981, there have been 95 separate legislative changes in the Food Stamp Program; 40 percent of these changes have modified eligibility requirements or benefit levels.

As advocates we are deeply concerned with the inherent inadequate level of benefits and with the apparent adverse effect of monthly reporting, retrospective budgeting, and the proposed error sanctions and mandatory work registration job search requirements. Our goal must be to increase access and to increase benefits to an adequate level. I'm afraid we are moving in the wrong direction.

Many critics of the Food Stamp Program claim that the program is plagued by fraud and abuse. The most reliable USDA data reveals that in 1983, about 20,000 food stamp recipients out of an average of peak load of 21.6 million were found to have committed fraud. Food stamp fraud involved less than one one-hundredths of 1 percent of all recipients and about seventeen one-hundredths of 1 percent of all total program benefits.

I said earlier that hunger threatens our national security. After years of slow but steady progress, the momentum has shifted against us. We hear much talk these days about national security, and in the past 3 years those of us who are in food service programs have seen a massive transfer of billions of dollars from programs that serve people to the military. But surely, the defense of this Nation depends on the health of our children as much as the size and numbers of our missiles. [Applause.]

This must mean freedom from hunger for our own citizens at least as much as military intervention in Central America.

Do you know that the cost of the military aid to the Government of El Salvador in the last year alone is three times what this country spends on nutrition programs for its elderly? The $5 billion that is budgeted in fiscal 1985 for the continued development of the MX missile could be used, instead, to provide 50 percent increase in the benefit levels of participation in the Food Stamp Program. That would be a giant step forward in reducing hunger in this country.

We have learned to live in a culture of have and have not. We coexist with certain inequalities and we teach our children the survival techniques of dull sensibilities. We learn to walk around certain people and to avoid bad neighborhoods. And we comfort ourselves with the inexplicable notion that somehow our Government is helping. But there is a point, and I think we all, as individuals, reach it at some point, when we begin to wonder outloud whether we have become too good at not noticing. A positive program to end hunger in America will not be forthcoming until we begin to reorder our Nation's priorities, so that once again people matter.

Thank you.

Mr. PANETTA. Thank you, Mr. Karp.

RESPONSES TO QUESTIONS FOR SAM KARP

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. With respect to the congregate and home-delivered meal services for seniors, you testified that restrictions which prohibit equal access must be removed. Would you explain these restrictions?

Answer. No response received.

Question. You mentioned the State appropriation of $5 million to increase home-delivered meal services from 5 to 7 days and to eliminate the waiting list for these services. How far has the State come in reaching this goal?

Answer. No response received.

Question. I understand that you operate a food bank that is part of the second harvest system. Would you give us some information on how requests for emergency food last year compare with this year's requests?

Answer. No response received.

Question. I have been informed that you food bank has a rather unique working relationship with the local agricultural community. Would you elaborate on this relationship?

Answer. No response received.

QUESTION SUBMITTED BY HON. MARGE ROUKEMA

Question. On page 4 of your testimony you make the following statement: "Here in California 4,000 senior citizens are turned away each day to congregate meal sites, and 9,000 others are on waiting lists to receive home delivered meals." What is the source of these figures? How were they compiled?

Answer. No response received.

[The prepared statement of Mr. Karp appears at the conclusion of the hearing, see p. 247.]

Mr. PANETTA. Let me ask, if I might, Ms. Hartsough.

You have indicated an increase in terms of the numbers of meals that are served, generally, throughout the city. Over what period of time? Over the last 12 months or more than that?

Ms. HARTSOUGH. Well, it's a continual increase, but we've been looking primarily at only the last year.

Mr. PANETTA. OK, let me ask you. We've had—at least statistically, anyway—indications of strong recovery in the country, economic recovery. Are you in any way seeing that reflected in statistics in terms of the FEMA program?

Ms. HARTSOUGH. No; I don't believe we are, because we are seeing more and more people in need of food; which indicates to us that economic recovery isn't going across the board. Some people may be recovering but a lot of people aren't.

Mr. PANETTA. The FEMA programs that you are looking at, are you seeing increasing numbers of children and families?

Ms. HARTSOUGH. Yes, very definitely. I think you will be hearing from some of the people, that actually provide their meals, on another panel.

Mr. PANETTA. All right, can you give me, on your own judgment or based on the evidence that you have found, some of the reasons why you think that has increased?

Ms. HARTSOUGH. Well, I noted the number of plant closures in this area—and, I think, all around the country—that the people who have been employed for long periods of time suddenly are finding themselves without jobs and are not finding it easy to find new employment. I think that is one of the big reasons.

I think that the new populations coming into our city are some of the refugee populations and the homeless. Young people, some of the mentally ill or chronically mentally ill, are people that have a harder time finding a job, particularly in this city which doesn't have a wide spectrum of jobs available.

Mr. PANETTA. Mrs. Roukema.

Mrs. ROUKEMA. I want to explore a little bit more your line of questioning.

You're reflecting my thoughts, back to, again, the paradox here that we are talking about. Despite billions—I mean the increase from $14 billion in 3 years includes some agricultural assistance programs, but it is, nevertheless, an enormous amount of money. And we're in a city, an area, of the country that is relatively prosperous—absolutely prosperous compared to many other areas of the country.

Now, help me understand why this problem seems to be accelerated, at least based on facts as you have stated them. I would like you to go into some other statistical data.

Do you have any data bank that you are using?

What is the statistical reference you are using to put these figures together?

And, for example, let's begin with what the unemployment rate is in the service area that you are speaking about. I would assume that San Francisco's unemployment rate has dropped overall, as it has across the country. Is it otherwise? Do we know?

My point is, I am not denying that there are people in need. I am trying to analyze, more deeply because we can't just say the answer to our problem is more money to this program or that program. That is one way of approaching a critical problem. But if it is chronic, what is the chronic nature of the problem? And there we have to get down to the job question, I think.

Ms. JAMES-HARRIS. One aspect of the chronic needs of the problem is that we have an increased number of homeless. San Francisco is everyone's favorite city, and not just visitors like yourselves come here. And people choose to stay here. We are limited in terms of available housing. The cost of housing is up. We have a significant number of homeless who've come just in the past 18 months. The mayor has spent over $2 million in care, for shelter and food for the homeless.

Mrs. ROUKEMA. Is part of this an immigration problem? Is that what you are suggesting?

Ms. JAMES-HARRIS. We have not yet begun to see the immigration problem in terms of undocumented aliens in the food programs in this city. The refugee populations have not participated; it is the usual populations that we are addressing right now. That problem would be escalated when we do begin to see an increase of participation.

Mrs. ROUKEMA. But what about the unemployment level? I would like——

Mr. KARP. If I may answer.

Mrs. ROUKEMA. Yes; go ahead.

Mr. KARP. I think there is a thin line here that we must talk about when we say that the unemployment level has gone down. The most recent statistic by the Department of Labor, their Bureau of Labor Statistics, in June 1984, said that in this last month that the number of persons who are officially unemployed and not receiving benefits—in fact, only 29.2 percent of those who are unemployed are receiving benefits right now—is the largest number—7 percent who are unemployed, not receiving benefits—the largest number of unemployed workers not getting those benefits in the history of the unemployment insurance program.

We have more people who are classified long-term, unemployed, out of work for 6 months and still looking for work, than we've ever had before; even greater than at the worst of the recession of 1982, when there were 6—5.9—million employed workers not receiving benefits: we now have 6.1 million. And it takes an average of 2 to 3 months longer before somebody can come back to work now than it did at the worst of the recession.

So, I think that simply by saying that the unemployment rate is down, particularly in our area where we have seasonal unemployment, because of agricultural work, for many undocumented workers who are not even counted, and the strange irony of those who put food on the table for America can't even feed their own families, is something that we experience here in California very severely. So, just looking at unemployment statistics alone doesn't really show the picture. [Applause.]

Mrs. ROUKEMA. Thank you very much.

Mr. PANETTA. If I could ask the audience—I understand your support for various positions; however, we are on a timeframe, and if we start clapping for every question we're going to be in a tighter timeframe; so, I would just ask you to hold back. I would appreciate it.

Mr. Leland.

The CHAIRMAN. Ms. Schutzman, last fall the county instituted a new, augmented issuance system for the Food Stamp Program.

Ms. SCHUTZMAN. That's right.

The CHAIRMAN. Will you explain the benefits of the new system as compared with the one you terminated?

Ms. SCHUTZMAN. The system that we terminated was the one that was fairly typical throughout California, except for those counties which mailed coupons directly to recipients. The old system required us to mail each month, to each recipient, an authorization to participate in the Food Stamp Program, which they took to an outlet to redeem for coupons. The new system allows us to enter a computer terminal which automatically transmits eligibility and benefit information to a food stamp outlet. The client is issued a plastic, magnetically coded card which is similar to your ATM card at a bank. He takes that to the outlet, the teller runs his card through a card reader and issues them, and tells him how many books he gets, how many coupons to get, and automatically reconciles all of the transactions by teller, by outlet, each day, so that we have virtually eliminated all of manual reconciliation that we used to do.

We've eliminated the unnecessary postage to mail out coupons to 25,000 households. The client receives one card that is valid for the entire term of his eligibility, so that he does not have to call us each month, asking where the authorization to participate is if it didn't arrive in the mail at that time.

This is, basically, an administratively very efficient system and can provide benefits to clients on a much quicker basis. When a client comes into the office to apply for benefits, and if he is in immediate need, under regulations we have 5 days to issue him benefits. Typically, we issue benefits on the same day or the next day. The client is issued a temporary card which he takes to the outlet and immediately transacts his benefits.

The **Chairman**. What is the cost savings of this approach?

Ms. **Schutzman**. We're still in the pilot phase. We're the first county to try this in California, and we don't have all of the figures in that. We do know that in the first month of implementation we eliminated duplicate issuance completely. We were typically issuing about 400 duplicate payments to clients per month, and in the first month of implementation it was zero.

The **Chairman**. Mr. Karp, you mentioned that you have to turn away people from the senior citizen meals facility. Appropriations for congregate meals have increased this year. How do you explain your need to turn away people?

Mr. **Karp**. You say Federal appropriations have increased each year?

The **Chairman**. That is correct.

Mr. **Karp**. That statement is correct; but in fiscal year 1983, I believe Congress appropriated $30 billion more for congregate meals nationwide. California gets about 10 percent of that allotment, so it would run about $3 million in California. In fiscal 1984, the additional appropriation was $2.5 million nationwide—of which $5 million by the House and the Senate went $2.5 million, and that's what the figure is. That brought an additional $250,000 for California, a drop in the bucket. Neither, in those years, was the increase able to keep pace with inflation. Food inflation in those years was high.

As I said before, we have had an increase in elderly population in this State and around the country. The graying of America is very real.

One other thing that has happened nationwide is that even though there have been these small increases in congregate meal allocation, there's been not a penny more in home delivery meals since Senator Kennedy amended the older American—in 1978, and which went into effect in 1980. And there has been no increase in social services. And what we have seen here in California and in every other State is that local area agencies are aging, bureaucratic-ridden level of this program. They've been transferring more money to social service programs, particularly to transportation, and transferring money to home-delivered meals where there's been more of an acute need. And I think that's why there continue to be people turned away.

Beyond that, in this midlevel bureaucracy we're seeing more administrative money taken off the top and less money going to services continuing here in California. We're also finding that the administration's response has been, besides recommending reductions in these programs, which the Congress didn't go along with, is that you go out and ask the senior citizens for more money. They instituted what they called a program income initiative—productivity initiative—which has some merit, but based primarily on seniors contributing more. Nationwide, I believe the figure is $117 million that elderly contribute on a voluntary basis simply from needs cuts in this program. It's a substantial amount of the money, about one-third of the national allocation.

The CHAIRMAN. I have two questions I like to ask very quickly. One is the cash-out program for senior citizens. Will you comment on that?

And, also, the use of surplus commodities and how that improves nutrition——

Mr. KARP. Well, very quickly on that. SSIF—California is one of the few—Wisconsin is still cashing out food stamps, but we cash out food stamps for elderly recipients. It works, but it works in a way that is much different than the intended purpose. The average allocation or benefit for an elderly person on SSIS is about $441; which is higher than in most parts of the country, but we have a higher cost of living here.

Rand—the Rand Corp.—did a study in the last year, and they found that for every dollar cashed out in food stamps, that only 14 cents was being spent on food. And the reason is that people were using it to pay the rent, paying the utilities, paying their increased cost of medical care, and so the cash out worked because so many more people were receiving it—so attached. And we found that in the pilot program that was established in 1977, in eight different areas around the State, which wasn't identical to the cash out in California—it called for—you went and applied for food stamps, and instead of getting a stamp you got a cash out, and more people participated. But here in California there just isn't enough money to go around. So, it worked but——

Commodities is a much larger area that I could respond to. It's a double-edged thing.

Mr. PANETTA. Keep it as short as you can.

Mr. KARP. Keep it short.

First, I should say commodities serve as a supplement, and they can't be seen as anything more than supplement. They do not replace pilot programs, they enhance. In the elderly programs in California we had a one-time bonus commodity. We were able to save the Department of Aging, estimated, about 15 cents a meal, which we could then produce more meals. But that was only a one-time thing.

We're having terrible problems: No. 1, we don't get enough; No. 2, delivery is irregular. And, in a letter, California requested that the Federal Government assist. We said, "What we need to have in the State department of education, at the request of USDA., we need to have time certain delivery, because we don't get delivery on the day that is stated, they just surprisingly show up."

It takes volunteers, for the most part, to unload these things by hand. Sometimes everyone is out, sometimes you just get a truck or trailer, and it causes problems because people can't accept it when they do, in fact, need it. The Federal Government, in a letter to Congressman Miller a couple of weeks ago said, "I'm sorry, but it's cost prohibitive for us to give you a time certain." Well, I think that's really false economy, because it's costing more money administratively for this State to have to shuffle around for all these different shipments. People don't get them. We're not getting enough.

The amount of commodities in storage now is unbelievable—1½ billion pounds of dry milk—1½ billion pounds. And we have children who are failing to survive here, who could use that milk. We can't access to it. We can't get access to honey, to corn—bumper crop of corn this year, bumper crop of wheat, bumper crop of soybeans. We have millions—hundreds of millions—of pounds of this stuff on storage that we can't get access to.

So, yes, commodities would help. They would help us supplement. It would help, if we were using them in mass feeding programs, if we could get 10- instead of in 4-ounce cans, if we could get it in larger amounts. Because the labor cost of opening the smaller ones makes it almost prohibitive to use them. I could go on and on.

Mr. PANETTA. Thank you.

I would like to proceed to the next panel unless there is some urgent question for this panel.

Mr. EMERSON. Mr. Chairman, I ask unanimous consent to insert in the record at this point some tables which relate to food assistance programs, both nationally and in California, including the WIC Program, congregate meals and home delivered meals. We've got to work from data. We have Government sources for all of this data, and I find our sources somewhat at variance with the allegations that are being made. I would like to submit these for the record at this time.

Mr. PANETTA. Without objection they'll be made a part of the record.

[The information referred to appears at the conclusion of the hearing, see p. 187.]

Mr. PANETTA. And without objection, we will keep the record open and those that wish to submit questions can do so.

And we would ask the panel to respond to those questions in writing for the record.

And thank all of you for coming here and for giving us the benefit of your experience and your testimony. Thank you.

Mr. EMERSON. Mr. Chairman, I wish to revise and extend my remarks at this point in the record.

Mr. PANETTA. Without objection.

[The additional statement of Mr. Emerson appears at the conclusion of the hearing, see p. 190.]

Mr. PANETTA. The second panel will focus on health and nutrition impact of existing food programs, with Dr. Fernando Mendoza from the University of California. Dr. Mendoza will be accompanied by Dr. Ricardo Castillo. However, I believe Dr. Castillo wasn't able to join us today. It will be Dr. Mendoza, accompanied by Dr. Ariska Razak, director, prevention of preterm delivery projects, Alameda County, CA; Lois Salisbury, an attorney for Public Advocates; and Karen Bertram, who is a nutrition consultant.

Thank you all for coming. As I indicated to the last panel about the timeframe, we would appreciate it if you would keep your comments to 5 minutes so that we would have some opportunity to question.

Dr. Mendoza, do you wish to proceed?

STATEMENT OF FERNANDO MENDOZA, M.D., ASSISTANT PROFESSOR, PEDIATRICS, STANFORD UNIVERSITY SCHOOL OF MEDICINE, STANFORD UNIVERSITY

Mr. **Mendoza**. I want to apologize that Dr. Castillo was not able to make it.

Dr. Castillo and I are both pediatricians, and we have both been involved in pediatrics for about the last 8 years. During that time we've been very surprised and dismayed at the amount of malnutrition that we are seeing in the Mexican-American population. For that reason we've begun to study this problem using some national data.

As you may know, the nutritional status of children is very important in pediatrics, because through this we can tell something of their overall health status. When children are malnourished, they show signs of poor growth, behavioral problems, and poor response to infectiuous diseases. So, therefore, a poorly nourished child can have multiple problems.

For the Mexican-American children there has been little data in the last 10 years with regard to their nutritional and health status. In fact, the Government has only in the last 5 years identified Mexican-Americans as a separate population. Therefore, we have a general lack of information on this population.

There have been, studies over the last 10 to 15 years that show the Mexican-American children are shorter and lighter weight than most other children. To evaluate this, we examined national data from 1971 through 1974, and evaluated this problem with regard to this population. We found that Mexican-American children are, indeed, shorter than most children, and they're also lighter weight. But this problem seems only to occur when the family income is below the poverty line established by the Government. Once they get above the poverty line, then the physical findings are not present.

How this applies currently, given that the data is from 1970, is the fact that in 1980 about 30 percent of Mexican families were below the poverty level. Therefore even though the data that we were evaluating is 10 years old, the problems may be very similar to the present situation. We currently see many small, thin children. When we talk to their families about what is happening, we find that they have very low income, and they don't have enough to feed their children.

Dr. Castillo and I have come to the conclusion that we need to achieve two goals in order to correct this problem: One is to continue to get better information with regard to the health and nutritional status of Mexican-American children; and, second, because children have a critical period of growth in their lives we need to do something about the problem now. During the first 3 to 5 years of life it is essential to maintain good nutrition. Therefore, even though we would all like more information about the problem, I think it is vital to do something now, because the children that currently are under 5 years of age have no time to wait for definitive studies.

So, if there are any questions that I can answer, I'd be happy to do so.

Mr. **Panetta**. Thank you.

Responses to Questions for Fernando Mendoza, M.D.

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. When health monitoring surveys identify groups as being at high-risk of malnutrition how do you recommend that Federal programs follow-up to reduce the risk?

Answer. Certainly one way to reduce the risk of malnutrition is to increase the food availabilities for this particular group at high risk. Such programs as food stamps and WIC could be targeted at the groups with the high-risk factors. Once such interventions were begun, then the group should closely be monitored to determine whether these interventions decrease the risk for malnutrition. Currently, as you may know, the only national surveys are the HANES studies, which are done on an every 5-year basis. Both Dr. Castillo and I feel that it is as important to provide close follow-up of these groups as it is to provide food supplements. Therefore, it may be reasonable to have the Public Health Departments locally monitor the effects of these intervention programs and submit data to a national center that would then compile and analyze the effects of federally funded programs. I think only in this way can effective programs to deal with the complex problem of malnutrition be developed and made efficient.

Question. In hearings across the Nation we have heard that food supplies for many of the families participating in the Food Stamp Program run out before the end of the month. Can these short periods of hunger or undernutrition have a health impact on growing chidren? If so, can you detail the impact?

Answer. Both Dr Castillo and I have seen clinically evidence of families having the problem that you described. That is families that toward each month may not have enough resources to maintain adequate food supplies for good nutrition. One of the other ways we also see this being manifested, and perhaps of a more serious concern is the fact that some families will tend to anticipate the lack of resources toward the end of and, therefore, decrease their caloric intakes throughout the month. For example, some mothers may dilute their infant's formula in order to have it last twice as long. In older children them may use the powdered milk at a less concentrated level so that the supply will last longer. Therefore, short term food deprivation that may be occurring in some families, particularly those below the poverty line, may translate itself as low-grade malnutritioned. The children of these families, because of the adaptive behaviors of their parents, develop increase risk for malnutrition. This can result in children who are shorter stature, children that may be more at risk for infections, and children whose behavior and cognitive abilities may be impaired. Last, we always need to keep in mind that children are dependent on their parents for providing them food. Therefore, malnutrition in the family can also have an effect on the parents in their ability in obtaining and in performing work, which in itself may determine the degree of stability of the family structure and resources.

Question. Your statistics and those of the 1981 Center for Disease Control Pediatric Nutrition Survey clearly show that Hispanic children exhibited growth stunting at much higher than the U.S. expected rate. From your work as a physician of low-income Hispanic families, how can we better target the Federal food and nutrition programs to reach this population to prevent malnutrition?

Answer. First, one thing that we need to have clearly in mind is that the Hispanic population is not a homogeneous group of individuals, but rather is quite heterogeneous. Hispanics not only differ somewhat in the characteristcs of their culture, but also to the extent that they are rural versus urban, Spanish speaking versus English speaking, acculturated versus nonacculturated. Also the degree to which the individual members of the Hispanic community have access to Government food programs can also influence how effective any of these programs will be to deal with malnutrition in the population. Therefore, when one speaks of targeting these programs for the Hispanic population, it would seem to us to be a fairly difficult task unless one had significant local input. This could be done in one of several ways. For example, the Public Health Department could be utilized to tailor the programs to better reach the population targeted. In this case the Public Health Department in south Texas could address the needs of the more Spanish speaking and less acculturated group of Hispanics as opposed to those in California which may be more acculturated and mostly urban. Local involvement, therefore, would allow tailoring of each program to the individual needs of the population. Another possible model of program management may be the cripple children services in which regional centers are used to monitor and control Federal funds directed at helping children with chronic disease. I can vision a possibility where regional centers are set up to monitor and carry out intervention programs to meet the needs of malnourished children in particular areas. This would allow for local economy, local surveillence, and local specification of intervention programs. These could then report to a national center for national follow-up.

Question. Physicians at Boston and Chicago hospitals serving the poor have reported an increase in the number of infants and children diagnosed with malnutrition-related diseases since the reductions in Federal food and health programs. Have you or your pediactric colleagues observed similar increases in malnourished children coming to your hospitals?

Answer. Yes, both Dr. Castillo at the San Francisco General Hospital and I at the Stanford Children's Hospital have noted a somewhat increasing number of infants and children with diagnosis of malnutrition-related diseases. These would include failure to thrive, short stature, and recurring infections. We are both seeing individuals that have recently immigrated into the Untied States with these problems. But also there are families that lived here permanently that have children with similar problems.

QUESTION SUBMITTED BY HON. VIC FAZIO

Question. How can we particularly find out and meet the needs of Mexican-Americans residing in rural areas?

Answer. One of the interesting findings of the demographic characteristics of the Hispanic population has been that it is changed from a primarily rural to an urbanized population. Therefore, less Mexican-Americans are living in the rural areas of this country. There also seems to be less transitory migration of the Mexican-American population than there was several years ago. All these factors have changed the needs of Mexican-Americans residing in rural areas. One of the ways to provide more current information will be through the Hispanic Health and Nutrition Examination Survey. This is a national survey that has included rural Mexican-Americans. This survey is very comparable to the National Health and Nutrition Examination Survey. With the information gathered in this survey, I think the health and nutritional needs of Mexican-Americans will become more defined. Some assessment to what degree they are being met will also be available. Therefore, the National Center for Health Statistics will be able to provide Congress with important information with regard to the Hispanic population of the United States once this survey is analyzed.

[The prepared statement of Mr. Mendoza and Mr. Castillo appears at the conclusion of the hearing, see p. 250.]

Mr. **Panetta**. Ms. Razak.

STATEMENT OF ARISIKA RAZAK, COORDINATOR, PREVENTION PRE-TERM DELIVERY PROJECT, ALAMEDA COUNTY

Ms. **Razak**. The problem of low-birth-weight infants, that is infants born weighing less than 5½ pounds, is considered the most critical problem in obstetrics today, for infant birth weight is the most crucial determinant of subsequent infant survival and wellbeing. Low-birth-weight infants are 20 times more likely to die within their first year as are normal weight babies. And very low-birth-weight infants, infants weighing less than 3½ pounds, are 300 times more likely to die in their first 28 days of life.

Low birth weight is also associated with an increased occurrence of mental retardation, learning disabilities, birth defects, blindness, autism, cerebral palsy, epilepsy growth problems, visual and learning defects, delayed speech, and chronic lung problems. According to the U.S. Surgeon General, "low birth weight is the greatest single hazard for infants, increasing their vulnerability to developmental problems and to death."

Infant weight at birth is highly dependent on the mother's nutritional status before and during her pregnancy. Poorly nourished women whose prepregnancy weight is less than normal and whose diets continue to be inadequate during their pregnancy, are much more likely to have a low birth weight and growth retarded baby than are adequately nourished women of normal prepregnancy weight. Women who gain less than 10 pounds in the first 26 weeks of their pregnancy or who lose more than 5 pounds during the pregnancy, are at greater risk of having a premature baby; and prematurity accounts for about two-thirds of all low-birth-weight babies.

Continual nutritional deficits in pregnancy also increase a woman's vulnerability to illness and infection; and illness and infection are, themselves, also associated with prematurity and low birth weight. Toxemia, or pre-eclampsia, is one of the most significant dangers to internal as well as infant well-being, and it is associated with low-birth-weight and growth-retarded infants. In its most severe form, it leads to maternal and infant death. Many medical authorities feel that toxemia is associated with inadequate protein consumption, and the standard medical treatment for women exhibiting signs of pre-eclampsia and toxemia include diet modification, increased protein, and nutritional counseling.

Inadequate maternal consumption of iron also places the pregnant woman and her unborn at significantly greater risk. And inadequate iron intake also predisposes a pregnant woman to infection, increasing her chances of premature and underweight babies.

Since a baby inside the womb cannot receive more than what its mother takes in, common sense tells us that a well-nourished baby needs to have a well nourished mother. But we have more than commonsense to tell us this. For the last 35 years, the Montreal Diet Dispensary has been providing milk, eggs, and oranges to low-income women attending public prenatal clinics. In fact, WIC, in part, was modeled after this program. Significant increases of birth weight for high risk—and they define them as underweight, poorly nourished and adolescent—women as part of their high risk group resulted.

I have seen a film depicting patients served by that clinic. One of the women in this group produced, without supplementation of the dispensary, five premature and low-birth-weight children. Every child she had had physical or mental handicaps as a result of prematurity and low birth weight. Her only normal child, that is the child born full-term or more than 37 weeks, was subsequent to the nutritional supplementation by the diet dispensary. Her medical care was no different. This kind of preventable waste in terms of human life and family suffering that the lack of adequate nutrition causes just cannot be tolerated in a society as rich as ours.

I have worked for the last 4 years with the Oakland perinatal health project, a project of various county and community clinics, outreach efforts and direct and indirect health care providers. I am here to tell you that comprehensive prenatal care, that is prenatal care that is given in conjunction with social services, nutritional services and health education, absolutely makes a difference in pregnancy outcomes.

And the cornerstone of many of our interventions, the most significant nonmedical intervention we can make, is through nutritional services. There is no other variable to which high-risk pregnant women and their infants respond as readily. There is no other nonmedical high risk variable that we can correct as easily.

For example, all of our statistics indicate that certain demographic factors place the woman at high risk. In our county, for example, the infant mortality rate for blacks has been between 55- and 70-percent higher than the infant mortality rate was for whites for the years 1878 through 1982. Black women have an incidence of low birth weight that is roughly twice that of white women, and Hispanic women and teenage women have an incidence of low-birth weight that is above the county average. This data is not unique to Alameda County but parallels national data.

Statistics from the Oakland perinatal project show that the high-risk status are not primarily genetic or physiological. Black women in our project, for example, experienced an incidence of low-birth weight that was essentially equal to that of white women in the project, 6.2 and 6.1 percent, respectively, and one that was substantially lower than the county average for all women. Teens experienced an incidence of low birth weight that was also significantly lower than the county average.

What I am basically saying by this is that while all our statistics indicate that black women or teenage women are at significantly greater risk, we can't change some of those rates, we can't change some of the aid. When we see that when we give women access to other services and counseling on their high-risk status, invariably then they become essentially similar to normal women.

When you ask providers what the variables are that make the difference, nutrition comes up again and again. When you talk to a teen about the reasons she needs to gain more weight, when you provide food supplementation to women who cannot afford it, when you counsel clients about protein equivalents in their non-American diets, you can change one of our most significant health care variables. Changing women's nutrition changes their pregnancy outcomes. Our project found that the number of prenatal visits was positively correlated with birth-weight increases. In other words, the more prenatal visits a woman had the greater the birth weight of that baby. There was a 13.6-gram increase in birth weight for each prenatal visit.

As head of the midwife service that managed 30 percent of the Oakland perinatal health projects, I can personally attest to the fact that increased prenatal visits meant increased nutritional counseling. One of the major reasons that we would have women come in more often is that they are not gaining weight or that their nutritional status was impaired. Women who did not gain weight have interim visits with the nutritionist. They had extra nutrition counseling from a certified person, a midwife, the nurse practitioner, or the doctor.

Referral to WIC was a standard part of our patient management. This was paralleled in clinics throughout the entire perinatal project.

We considered food supplementation indispensable. There are many, many women that do not have enough to eat and that need the protein supplementation of WIC. The fact that WIC is tied to health care clinics is a positive encouragement for women who might otherwise be poor clinic attendees. WIC nutrition workers are often perceived by clients as credible sources of health information; their counseling and reinforcement of the health teaching that we have provided is a welcome addition to the health care team.

In summary, we need to continue and expand nutritional services to pregnant women. These services are absolutely necessary if we are to successfully reduce the incidence of low birth weight and prematurity. Every dollar spent on nutrition can save $3 in remedial care. In our county-based WIC services, we are rapidly approaching the maximum number of patients we can serve. But the need for WIC in our area is increasing, not decreasing. We need to expand these services.

Thank you.

Mr. PANETTA. Thank you very much.

RESPONSES TO QUESTIONS FOR ARISIKA RAZAK

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Evaluation studies of WIC indicated that birth weights are substantially improved for women who enroll in WIC early in pregnancy. Is late enrollment for prenatal nutrition services common in your county?

Answer. No response received.

Question. What can the Federal Government do to help bring women into WIC services earlier in pregnancy?

Answer. No response received.

Question. What suggestions can you make to ease the administration of food stamps, medical, and WIC for clients and providers?

Answer. No response received.

Question. Nutritionists working with WIC often tell us that the WIC food package is shared by all members of the family and not eaten only by the person for whom it was prescribed. Can you explain the causes and consequences of this?

Answer. No response received.

QUESTIONS SUBMITTED BY HON. VIC FAZIO

Question. How is the targetting of assistance decided between urban and rural areas?

Answer. No response received.

Question. What are our infrastructural needs in order to better enable access of WIC services to rural populations?

Answer. No response received.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. Can you tell us what causes low birth weight? You have mentioned the mother's nutritional status—a very important phase. Are there any other factors causing low birth weight?

Answer. No response received.

Question. Earlier this year a subcommittee on which I serve had a hearing at which a representative from the Centers for Disease Control testified concerning the pediatric nutrition surveillance system. According to the physicians the CDC data, which represents results of initial screening evaluations for infants and children before they begin to receive WIC benefits, or any other type of benefits show a modest improvement in the nutritional status of children especially those under 2 years. Would you comment on this and tell me if you have seen the same imrprovement in the nutritional status of children especially those under 2 years. Would you comment on this and tell me if you have seen the same improvement in Alamedo County?

Answer. No response received.

Question. It has been stated that the WIC Program has resulted in a dramatic decrease in infant mortality and in the number of low birth weight babies. That is good. However, can you tell us what steps you are taking to improve these rates even more?

Answer. No response received.

Question. What kind of nutrition education programs do you operate? Are you familiar with the Expanded Food and Nutrition Education Program, EFNEP, operated by the Cooperative Extension Service? Can you comment on this?

Answer. No response received.

[The prepared statement of Ms. Razak appears at the conclusion of the hearing, see p. 251.]

Mr. PANETTA. Ms. Salisbury.

STATEMENT OF LOIS SALISBURY, ATTORNEY, PUBLIC ADVOCATES, INC.

Ms. SALISBURY. Thank you. I am the advocate of a nonprofit public advocates law firm, and my presence here today is on behalf of minority women and two project organizations who have been profoundly concerned about the widening gap in mortality in general.

Indications that we have of our child nutrition health in this country would suggest that we have a profound discrepancy, a profound inequity, in our ability to take care of the children of this country. We have a very different health profile from conception onward for the minority child than we do for the typical middle-class child.

It is my particular pleasure to come before Mr. Leland again. It is the third time we've had within the year to come before one committee or another which he has been on, addressing this critical issue. And certainly this speaks of his commitment, and I know of all on the committee's, to try to close this gap, to see an end of the inequities. It is a pleasure to help the health individually as well as the health of this country.

Public Advocates had been active in the question of nutrition in a wide variety of advocacy efforts ranging from infant and perinatal health of Californians, to fix the price of milk, to the widening gap of infant mortality. Today I expect specifically to speak about the cost of infant mortality, particularly the difference between black and white mortality rates which fundamentally relate to our inability to bring all people into our health care system—which brings us to the question of nutrition access.

The comments of the preceding speaker could not be more directly to my point—that the health care system has been incorporated into a variety of systems which include the most fundamental medical checks as well as official counseling and access to food.

The fundamental problem that we have in this country is embarrassingly high infant mortality rates all across the country; although, significantly, the black rate is twice as high as the white rate—is a little different problem, that we just heard so much about.

Low birth weight is the reason why the United States has ranked an embarrassing 14th to 18th among the 25 industrialized countries for the past 17 years. There is really is no excuse to justify why this country, with its enormity of technological know-how and resources would measure up so poorly with other industrialized countries. But the underlying reality of that, the underlying reason for that low ranking, is the inadequate way in which we serve, particularly, our poor and minority families in terms of bringing them into the health care system. This, frankly, is very sad in the real figures, which, in the aggregate, sometimes is nothing, but for the pain of the experience in the loss of a child the pain can be overwhelming.

For example, if the United States had in 1 year, the year of 1977, enjoyed the lower rate of infant mortality that Japan enjoyed, we would have saved 17,000 children. If black children, families for these children, for the years 1978 to 1982, had similarly enjoyed the lower rate infant mortality that white families benefited from, we would have 19,000 more black children here with us today.

And the difference is not a function of location, be it here, in Japan or in Sweden, it is a function of access to health care. Because, as we've seen, once a family has been brought into that system, we suddenly see their low-birth-weight rates—which is really the core of the problem—tumble down, and their infant mortality rates tumble down, and begin very quickly to approximate the rates among the white population in this country, and among our industrialized counterparts in Europe and in Asia.

The fact is, unfortunately, we've seen phenomenon which indicate that we are doing just the opposite, we are failing at higher and higher rates to bring our low-income population into the health care system so that they will receive that essential prenatal care which is so fundamental and also includes nutrition. For example, right here in the bay area we've seen a rise in the low-birth-weight rate, a significant rise, over the last several years. In the black rate alone we've gone from the 1980 rate of 11.3 per 1,000 to a 1982 rate of 12.3 increase.

Excuse me. These percentages are not per 1,000.

Those rates are directly correlated with infant mortality. And that is particularly hard to accept in Alameda County, because, as we've just heard, Alameda County is, if anything, a county that has made a high concentration of effort to reduce infant mortality, in special focus; but the cutbacks that we've seen from both Federal Government and State government have translated into a reversal of what was a steady rate of progress where resources at the State and local level were targeted at the most profounded affected areas in terms of infant mortality.

But that is, of course, not a unique community. You can look at every pocket of poor minorities in the bay area and you'll find similar statistics, with the increased lack of prenatal care indicating an increasing rate of low birth weight, indicating a widening gap in the infant mortality rates between blacks and whites.

On a nationwide basis we also know that prenatal care, which is the essential key to unlocking this problem to bring our Nation to equity, when it comes to a fair start on life, is more and more being shown—particularly over recent years. The Children's Defense Fund study of 35 States which kept prenatal care access data, in 1982 showed that 22 to 35 States indicated more women blacks had no prenatal care or late prenatal care. For those States that indicated different rates, it was on a greater increase: 18 of the 23 States showed that the minority populations—there were increasing numbers that were getting no prenatal care; the day they had the baby was the first contact with medical treatment, or late prenatal care. If you don't have prenatal care, you don't know about nutrition, you don't have weight assistance; and the very factors are a risk to nutrition as other factors are never addressed in a preventive way.

One statistic that was particularly alarming to me in terms of the nutritional aspect of low birth weight is that we know that of the low birth weight that we see in blacks, which is twice as high—sometimes 2½ times as high—as the white population, over half of that is accounted directly to nutrition. The gap is a nutritional gap. That is what those statistics tell us, that we have half the black population producing low-birth-weight babies because of nutritional deficiencies, and we have a rate twice as high. That tells us a great part of the answers to why we have such a tragically high black mortality rate in this country.

We do know that these high mortality rates correlate to high risk factors. We do know that every one of these factors is a social factor, not a physical factor, that it is even true for the teenage pregnancy. The teen, once she is committed to having that child, is entitled to have a healthy baby. And it is not her age that prevents that, it is her inadequate access to resources and to nutrition. She is just as capable as a woman in her twenties or one in her thirties of having a healthy baby. It is not because she is young, it is because she is outside of the system and we're not doing enough to bring them in.

In addition to the correlation of rates, poverty, age, there is an environmental factor—particularly, since we are here to address the urban question, I would like to emphasize that—which is that even if you do have money to spend on food, whether it is food stamps, income, or some solution of resources, that money is not going to go as far if you live in the inner cities of California, live on the east coast, or every other city we have as if you are able to shop in the suburbs. The great irony is that the people in this country with the least amount of money to pay for food are paying the most for it, because we've suffered a major exodus of competitive price food chains from those communities. This is the problem that we in the advocacy effort have focused on, and one the outgrowths of that effort has been farmers markets, as you've heard mentioned earlier today, cooperative markets. There are real solutions that can be fashioned when. What we try to do is to find ways to make an enterprising phenomenon to bring food into the inner city. It does not need to be a charity phenomenon, but the fact is that for an inner-city resident, food stamps are not going to go as far as for a suburban resident's food stamps. Most of the cities' residents are paying probably 20- to 30-percent higher for their food, and the quality of that food is not the same. Women, in particular pregnant women, and the elderly have totally cut out fresh fruits and vegetables and poultry and meat from their diet altogether because they can't buy it at the liquor stores where they have to shop. Everybody that has lived in the inner cities knows that it is widespread and it's worsening, and one that I would ask the full committee, in its larger focus on structural problems in this country, to pay attention to.

The positive side of what we're talking to you about is that we do know that there is much that can be done, national programs with very impressive track records, and we do know that the track records are cost effective. On a State basis the California Oakland access project or the Pacific access project was shown precisely to pay at least $1 for every $1 that was spent.

We did an extensive analysis in our mortality rates which was presented to this committee, and showed that in medicaid dollars alone. Because a baby that is prevented from gaining normal birth weight does not—in medicaid dollars alone, the Federal Government would save $400 million by making sure that prenatal care is given from the beginning rather than addressing these problems after the fact. That $2 or $3 million doesn't begin to take into account the loss of life. It doesn't begin to take into account the lifetime disabilities that are so highly associated with being formed to small in the first place.

The same kinds of problem solving procedures are available on which no one has a difference that they are very beneficial, because in that way the baby is nurtured, the child in the womb, and brings a strong, healthy baby into the world.

WIC is specifically shown to reduce the rate of low birth weight. For example, one Massachusetts data shows that by comparing a WIC group of women who are not brought into the system, that do not benefit, that the WIC would have one-third the rate of infant mortality than the non-WIC group. That means, fundamentally, they have a much lower birth weight——

Mr. PANETTA. Ms. Salisbury, I'm going to have to ask you to summarize.

Ms. SALISBURY. Yes; I would like to simply emphasize how the system has move rapidly to help the Child Health Assurance Program. The Child Health Assurance Program, however, is incomplete until we also seek comprehensive prenatal care included in the standard of care. And my predecessor detailed components of prenatal care, which particularly include nutritional assessment and counseling and bringing them into methods, either WIC or otherwise, to make sure that she gets the nutritional component that she needs.

We also see a tremendous need for widespread education. Because even in those States which have access to the prenatal care, access to WIC, for those communities there is widespread misunderstanding, ignorance, about the need. And we believe that the best way to reach those communities is to take advantage of the technological know-how that we have—radio, television, bill boards, in those communities—advertising all the important prenatal care to in some ways counter-balance the misunderstandings that have dominated those communities. Our goal is to engage women in the system, because we know that as they are brought in it makes a difference.

Finally, I simply would like to urge the committee to adopt a very broad plan, to start looking at some of the underlying analytical factors like access to food in the inner city, because those factors play into the fine tuning that we're talking about now in the WIC Program, in the Medicaid Program.

The fundamental reality that we have now is that there is going to be more and more loss of life if we don't somehow address the nutritional problems and structural problems that have created that phenomena. Thank you.

Mr. PANETTA. Thank you.

RESPONSES TO QUESTIONS FOR LOIS SALISBURY

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. From your study of WIC evaluation reports which groups have you found to benefit most from participation in this program?

Answer. Various studies confirm that WIC is effective in ensuring healthy pregnancy outcomes for participants enrolled during the prenatal period. Specifically, WIC participation has been found to increase weight gain, thereby reducing the rate of low birth weight and resultant infant mortality, to achieve cost savings, and to draw women more completely into an adequate program of prenatal care, including their nutritional needs. See, for example, work authored by Eileen Kennedy, Harvard Public Health School, Milton Kotlechuck, Massachusetts Department of Health, Jack Metcoff, University of Oklahoma Health Sciences, and the Mississippi Health Department.

Question. In your testimony you stated that in medicaid dollars the Federal Government could save 400 million dollars by making sure that prenatal care is given from the beginning of the pregnancy rather than after the fact. Would you explain to us how you arrived at this figure?

Answer. The figure reflects the savings in medicaid dollars alone of preventing low birth weight through adequate prenatal care, thereby preventing enormous Federal expenditures on intensive care and rehospitalization for low birth weight babies during the first year of life. The savings of a $400 million takes into account the increased costs to medicaid for providing comprehensive prenatal care, as defined in both our administrative petition, my written testimony, and the testimony of others at the San Francisco hearing. Finally, this cost savings figure is based upon the best data available documenting the numbers of women where medicaid did not provide their prenatal care, but where medicaid nonetheless covered their deliveries, postpartum care and intensive care and rehospitalization for their infants. The figures for comprehensive prenatal care include picking up those women who previously were only medicaid eligible once the baby was born.

The cost savings figure was mathematically computed as follows: It currently costs the Federal Government $638,364,300 to pay for neonatal intensive care, NICU, and rehospitalization for low birth weight infants during the first year of life. This figure could be reduced to only $90,000,040 if comprehensive prenatal care were available to all low-income women. The additional expense of providing such comprehensive prenatal care is $187,084,000. By subtracting the costs of the additional coverage, $187,084,040, from the projected savings of $548,165,260, a final cost savings figure of $361,081,220 is obtained.

Current Federal cost for NICU and rehospitalization	$638,364,300
Federal cost after providing comprehensive prenatal care	−90,199,040
Subtotal	548,165,260
Federal cost for providing comprehensive prenatal care	−187,084,040
Savings to Federal Government	361,081,220

For a complete explication of the methodology utilized in deriving these figures, please see the Administrative Petition to Reduce the Incidence of Low Birth Weight and Resultant Infant Mortality, pp. 96–133, which was provided to the committee and which we requested be included in the record.

Question. I am aware that you have petitioned the State government to improve access to low cost foods for the urban poor. In your research what access barriers did you find affected the food buying power of the urban poor?

Answer. The single greatest barrier to food buying power in the inner cities of California, and indeed elsewhere, is the lack of competitively priced stores located in those communities. In short, the competitive supermarket chains have steadily abandoned those communities; in many areas, the only places left to shop are mom-and-pop stores and liquor stores. Thus, already greatly resticted dollars must be spread even further, because food is both very expensive, 20 to 30 percent higher than at supermarkets, and quality is often poor, with fresh produce and meat frequently unavailable. For a complete explication of the problems of inner city food access in California, please see the enclosed copy of the Public Advocates' Administrative Petition to State Government, filed in the Fall of 1979. The problem has only worsened since that time.

Question. What Federal recommendations for legislation can you make to alleviate this problem and thus expand the food buying power of the urban poor?

Answer. Public Advocates filed an administrative petition in the fall of 1980 alerting Federal administrative agencies to the inner city food crisis, and recommending solutions. The centerpiece of those recommendations was providing incentives to encourage food marketing plans tailored to the inner city shopping profile—heavy on the purchase of foods and necessities, but light on the sale of other nonfood items often purchased in suburban supermarkets at heavily marked up prices. Bringing markets back into the inner city, be they independents or vertically integrated national chains, will require substantial incentives combined with active community involvement and responsibility. Additionally, the petition outlines solutions which encourage the development of cooperative markets, direct marketing between farmers and consumers, urban agriculture, and joint ventures between established food retailers and community organizations.

I have enclosed for your information a complete copy of the petition, which is over 50 pages long. The petition outlines requested action on pp. 53–56. Please include these pages as an exhibit augmenting my answer to this question.

Question. I am aware that you have submitted an administrative petition to the Department of Health and Human Services and to the Food and Drug Administration regarding the promotion of breast feeding. What benefit have you found for low-income women who breast feed?

Answer. An inquiry into the benefits of breast feeding must, of necessity, also explore the only alternative, bottle feeding. It is the strong recommendation of major national and international medical associations that infants be breastfed. The studies of morbidity and mortality comparing breastfed to bottlefed infants, as well as recent scientific information, reveal important nutritional and immunological advantages for breast feeding. The morbidity/mortality data outlined in the petition—copy enclosed—conforms to the well documented pattern of breastfed infants having a significantly decreased incidence of infections during their first year, particularly intestinal and respiratory tract infections. Indeed, there is wide scientific agreement that breast feeding affords dramatic protection against many serious diseases in infancy, and that without this transitional protection in the first few months of life, the infant is dangerously vulnerable.

Since low-income women are at greater risk of producting a low birth weight baby who, in turn, is at greater risk of suffering intestinal and respiratory tract infections, the particular benefits of breast feeding to low-income women are apparent.

Moreover, the information contained in the petition cited in your question documents that when bottle feeding is the choice exercised for infant nutrition, there is a greater likelihood among low-income families that some of the risks associated with bottle feeding are increased. Specifically, there is significant documentation of inappropriate preparation or dilution of the formula among low-income families, especially those whose native language is other than English. The misuse is manifested in frequent trips to the emergency room reporting diarrhea and gastroenteritis, iron-deficiency anemia, and related conditions.

Very little has actually been published on the relation of feeding mode ot morbidity among low-income groups in this country, although some studies have been conducted among Native American populations. These indicate that bottle feeding yields even greater increases in morbidity and hospitalization among such low-income groups than it does among the middle class. It appears that low-income groups' babies at doubly at risk from the use of formula because:

(1) Like all infants they face nutritional and immunological deficiencies from formula compared to human milk; and

(2) They also risk severe health problems from being fed formula that is underdiluted or overdiluted, made with contaminated water, not properly sterilized, or has spoiled.

[The prepared statement of Ms. Salisbury appears at the conclusion of the hearing, see p. 253.]

Mr. PANETTA. Ms. Bertram.

STATEMENT OF KAREN M. BERTRAM, NUTRITION CONSULTANT

Ms. BERTRAM. Good morning. My name is Karen Bertram, and I am a community nutritionist-dietitian and have worked for the last 3 years in a community health center serving primarily low-income clients, primarily Hispanics and Indochinese refugees. I have a longstanding interest in the issues of both domestic and international hunger, and I appreciate the opportunity to address this committee this morning.

I also appreciate efforts of this committee to address the problem of hunger and to formulate appropriate solutions. My comments today will focus on nutrition education, its importance, its availability, and the need for its inclusion in Federal policy.

The reality of hunger and its consequences have been well documented by the previous speakers and by numerous studies. We respond to the problem on three levels: Immediate relief, short-term projects, and long-term programs. Relief programs like the local food banks and feeding programs are extremely important because they provide food, the basic means of survival. This is essential and is obviously of primary importance. However, as the well-known saying regarding giving fish and teaching to fish reminds us, our Federal policy must go beyond immediate relief and short-term projects. We must consider the long-term efficacy of Federal programs. We must look beyond just giving food to giving both the means and the knowledge to acquire an adequate diet. We must also provide nutrition education.

Nutrition education is the means by which the most recent research and scientific findings are translated into actual eating behaviors. The goal of nutrition education is to affect change in eating behavior, thus it is more than just disseminating information or increasing knowledge. Effective nutrition education improves the food choices that individuals make on a daily basis.

The history of our current Federal food programs is interesting in that each program originated with, and was conceptualized as having, a nutrition education component. The food stamp legislation was based on a 1961 pilot program that had a nutrition education component. The food stamp legislation referred to nutrition education but it was never funded. The National School Lunch Program is the same, it also had a nutrition education component, but it was only in 1977, 31 years after the program began, that funds were allocated for nutrition education and training, the NET Program.

It is also interesting to note that our most successful Federal programs, in terms of documented changes in eating behaviors, are those which have nutrition education as a mandated program component. These programs, namely, WIC, NET, and EFNEP, have documented their effectiveness in changing eating behaviors.

My written testimony includes the salient findings from recent evaluations of these programs which document their effectiveness.

I have also prepared this summary of nutrition education programs available in San Francisco, specifically. It is the blue sheet attached to the testimony.

Let me just briefly highlight two recent surveys of the perinatal population of San Francisco. At Health Center No. 4, a survey of the dietary intake of Indochinese prenatal patients revealed that prior to nutrition intervention 50 percent were below two-thirds the RDA for calories. 80 percent were below two-thirds the RDA for calcium, and 75 percent were below two-thirds the RDA for iron. This highlights the need and the importance of nutrition education.

At the teenage pregnancy and parenting project, participants receive a national school lunch, but the National School Lunch Program does not have a dietitian on its staff. Two dietitians recently found that the lunches were based on the minimum requirements for grades 4 to 12. This means that lunches provided only 40 percent of needed calories and only 51 percent of needed protein.

The population in an urban area like San Francisco poses challenging barriers to effective nutrition education. These barriers include: Poverty; inadequate funding; extreme ethnic diversity resulting in language and cultural barriers; insufficient culturally sensitive nutrition education material; insufficient bilingual staff; limited outreach; and lack of transportation. Thus, the following are my recommendations for Federal policy:

First, encourage a long-range planning approach to assure optimal nutritional status and health.

Second, encourage adequate funding to maintain and expand the nutrition education component of the respective programs.

Third, provide adequate access to food through existing programs, but with more timely, up-dated regulations.

Fourth, encourage creative avenues of program cooperation to maximize the effectiveness of scarce resources. An example of this could be having an EFNEP work closely with the Food Stamp Program.

Fifth, assure that qualified personnel, for example a registered dietitian or nutritionist, is responsible for nutrition education and staff training.

Sixth, provide planning for culturally appropriate nutrition education material.

Seventh, support efforts to monitor the nutritional status of the U.S. population, with specific emphasis on high-risk groups.

Again, I appreciate the efforts of this committee and will be glad to provide further information if necessary. Thank you.

Mr. PANETTA. Thank you very much, Ms. Bertram.

RESPONSES TO QUESTIONS FOR KAREN BERTRAM

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Do you see many people with chronic diseases, such as diabetes and hypertension, who do not have adquate resources to purchase proper foods to maintain diets to control their chronic maladies?

Answer. I kept statistics on my nutrition encounters for a 3-year period. I saw an average of 70 patients per month. Of these, 16 percent had hypertension as their primary diagnosis and 20 percent had diabetes.

Most of my patients complained that they did not have adequate resources to purchase proper foods. Often they would describe their income and compare it to their monthly bills. Many did not have phone service nor own automobiles, yet they still did not have adequate income to purchase fresh fruits and vegetables which they considered luxury items. I distinctly recall one diabetic man who literally could not afford anything but tortillas and beans.

The dietary treatment of most chronic diseases does not require expensive speciality items. Proper treatment does require knowledge about which foods to purchase. Nutrition education is of primary importance in teaching how to select the proper foods within a limited budget.

Question. What suggestions do you have for Federal food and nutrition policy to meet these needs?

Answer. 1. The first and most important action is to update the thrifty food plan, TFP. The TFP is used to determine food stamp allotments and is somewhat unrealistic. It assumes that the consumer will purchase the most nutrient dense foods at the lowest price. It does not allow for discretionary spending. Research has documented that low-income individuals do purchase more nutritious foods per dollar than their middle and upper income counterparts. However, to achieve adequate nutrition based on the thrifty food plan, the consumer must be very knowledgeable and informed regarding the nutrient density of foods. This is not the case for most low-income individuals.

2. The TFP must also be updated yearly using a method which more closely reflects current food prices. At present, the TFP is updated in October using June prices. By the following September the food stamp allotment is based on prices which are 15 months old. It is possible to project prices using an average inflation rate and provide a more realistic food stamp allotment.

3. The TFP should address other concerns. Currently it does not account for the following:

Cultural or religious preferences; special nutrient needs of population groups like the elderly; differences in food prices regionally; and limited access to competitively priced food stores for individuals without transportation.

4. Finally, nutrition education should be provided in conjunction with all Federal food programs. For example, if registered dietitian/nutritionists were employed by Food Stamp Programs a variety of options for education would exist. These could include the following:

Simple nutrition education sheets enclosed with monthly food stamps; education on cost saving methods for selecting the most nutrient dense foods, with a focus on seasonal variation; nutrition education classes and demonstrations in waiting rooms—the waiting rooms of most Food Stamp Programs are always full; individual counseling and/or referral for those with chronic disease; and updated price comparisons of local markets.

Question. What indicators do you have that your clients are not getting enough to eat?

Answer. In addition to the verbal accounts, which I described above, I saw marked improvements when they began participating in Federal Nutrition Programs. The most dramatic improvements were in Indochinese pregnant women. Very often I saw women in their fifth month of pregnancy who had not gained adequate weight, 1 to 3 pounds verses the normal 8 to 10 pounds. They agreed to eat the proper foods, but stated they could not afford them. We would immediately enroll them in WIC and the next month the weight gain would be normal. This was very gratifying in addition to preventing the complications and costs of low birth weight infants.

Another obvious indicator that people did not have enough to eat were the numerous requests for referral to the emergency food bank. As a board member of the food bank, I was responsible for all requests from my agency which I received regularly. The food bank records the number of individuals served if you should want this information.

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. I understand that you have been involved in setting up urban gardening projects in this area. Can you describe the process in setting these up and the benefits of urban gardens?

Answer. I was involved in setting a community garden project in Merced, CA. I initiated the project primarily to address the needs of the 4,000 Indochinese, Hmong, refugees that rapidly migrated to Merced. All ethnic groups were invited to participate, but only two to three nonrefugee families requested plots. The process was:

1. Convince the city social services director and his committee of the worth of the project.
2. Draft a management plan for allocating plots, etc.
3. Look for land. I contacted some private real estate companies, but finally found city land in a perfect location within walking distance for most low-income refugees.
4. Gain broad based community support.
5. Prepare and present a plan to the city council. The city donated the land and water. The local junior college donated the supervision of installing the water lines; students provided the labor. The community action agency donated some management time to assign plots. Many churches donated seeds and equipment. It was, and is, extremely successful due to the broad community support.

Merced is not an urban area; however projects similar to this have been successfully implemented in San Francisco. There is a large community garden movement and there are between 15 and 20 gardens throughout the city.

The benefits of the community garden project were numerous, they included:

Increased nutritional adequacy of the diet, most foods grown were fresh vegetables; increased purchasing power of the household; provided an opportunity for the elderly to have a distinct role and integrate with the broader community; provided training opportunities for students; and increased community pride and cohesiveness by implementing a successful project.

Question. Can you compare the benefits of WIC and the Commodity Supplemental Food Program (CSFP) both of which operate in this area? What about the nutrition education components of each program?

Answer. This is an excellent question given the unique history of both programs in San Francisco. Although I am familiar with the WIC Program in general, I am not well acquainted with the specific operation of the CSFP in San Francisco. Thus, I am asking the nutritionists at each program to respond to this question.

Some general comments regarding the CSFP in comparison to WIC include: the CSFP is not as comprehensive; CSFP does have a nutritionist on staff; CSFP is not as integrated into the health care system; the foods are not as targeted to the nutritional needs of pregnant women; and there are problems with distributing the food, for example a woman with children who has no transportation would have difficulty carrying the commodity foods home on a bus.

[The prepared statement of Ms. Bertram appears at the conculsion of the hearing, see p. 510.]

Mr. PANETTA. Mr. Emerson.

Mr. EMERSON. Mr. Chairman, I have questions I would like to ask of all of the witnesses, but we do have some time contraints here and I would ask unanimous consent to submit these questions in writing and to have the response appear at the end of each witness' testimony.

Mr. PANETTA. Without objection.

This would apply to all panelist members, so that the task force can submit questions and then we would ask the panel to respond to those questions and they would appear on the record.

Mr. EMERSON. Mr. Chairman, may I also ask unanimous consent to insert into the record the California State Plan for Management of the Nutritional Education Training Program.

Mr. PANETTA. Without objection.

Mr. EMERSON. You know, nutrition education is one of my interests and California has a lot to offer.

Mr. PANETTA. Without objection.

[The material referred to above appears at the conclusion of the hearing, see p. 191.]

Mr. PANETTA. Mrs. Burton.

Mrs. BURTON. I agree. In the interest of time, and particularly being from San Francisco I have the opportunity of being able to see you and talk to you; and I hope we do that. So, I will forego any questions right now.

Mr. PANETTA. Mr. Morrison.

Mr. MORRISON. I have written questions that I will submit.

Mr. PANETTA. Mr. Fazio.

Mr. FAZIO. Mr. Chairman, we ought to go on and hear the remaining witnesses. I appreciate the opportunity, though, and we will submit questions.

Mr. PANETTA. Thank you all for coming to testify and giving us the benefit of your expertise. You've been extremely helpful to us.

The final panel consists of: Rev. Cecil Williams, the pastor of Glide Memorial Methodist Church that we are pleased to have these hearings in; Father Floyd Lotito, who is director of St. Anthony's Dining Room in the area of San Francisco; and Louie Gonzalez, who is regional public affairs manager, Safeway Stores, and a board member of the Santa Clara Food Bank.

If we could have all three of you come forward.

Gentlemen, we want to thank all of you for taking time to come before the task force, and, in particular, Reverend Williams, for allowing us to hold our hearing here and for hosting our hearing at your church.

Reverend Williams, you may proceed.

STATEMENT OF A. CECIL WILLIAMS, MINISTER, GLIDE MEMORIAL UNITED METHODIST CHURCH

Mr. Williams. Thank you very much. I would like to welcome the panel from Washington to San Francisco and to our church.

I presented my statement, but I want to highlight just several things at this particular time.

For those of us who have been working some 15 years here at Glide with feeding people, we have come to the conclusion that we must begin to look at how we respond to people who are being fed, that to a great extent we have to even define somewhat the term hunger, and we must look seriously at what we call people who are being fed and the places where they come. For instance, soup kitchens is a term that I detest. I think it is demeaning, it is degrading, and, therefore, would like to invite those of us who are concerned about feeding people to redefine our terminology. Call it food kitchen or soul kitchen, not in ethnic terms but soul in understanding humanity and its response.

Therefore, I hope that when we feed people we will work to feed them in dignity and pride rather than just looking upon them as giving them the leftovers of what we might be able to get for them in regards to giving them the least that we can provide for them. People who are hungry need a balanced diet just like those who've been getting a balanced diet all of their lives, and it is my hope that we will, in fact, begin to feed people who come to us for food in a new way and in a new response. That is the first thing I would like to say.

Second, I would like to say—and I hope that you will change this in my statement—it is not the unemployed, it is the underemployed—a sociological term that is in use by the experts at this particular time—the underemployed will be with us, from all indications. They are the people whom we see as alcoholics, winos, drug abusers, mentally disturbed, those who are engaged in crime to one degree or another, bad women or whatever other terms you want to call them, they are going to be with us. It is most difficult for them to break out of the poverty cycle. We haven't done very much, and I don't think we're going to do very much in the present as well as in the future, to break that poverty cycle for the underemployed.

Therefore, we are going to have to continue to feed them, because we're convinced that the first thing people who are in poverty need most of all is food for their hunger. I could cite for you time after time the people who have said to us: "I did not go to jail last night because you fed me last night, I did not commit a crime last night because I got some food." The important thing is, I am convinced, that in regards to the supply and the techniques, food, first of all, is critical, so the underemployed is going to be with us.

Second—and this is the one I'm really going to try to bring home—what is called the feminization of poverty by the experts has, and is, on the increase. These are single women with children. The proportion of percentages of the tremendous increase that we now see in our food lines is astronomical. We are utterly surprised. We are moved, because in many ways the problem with the feminization of poverty is the fact that we are dealing with, first of all, people who have been victimized by our society, women who have been victimized, battered, raped, incest, all kinds of immediate and, in turn, related personal relationships. But not only that; in a real sense it is because we still see women as second-class citizens. And in many ways our response to women is a phenomenon which none of us really wants to grasp because it is difficult. It has been very difficult especially for us to comprehend and take seriously the poverty cycle in which women are caught. Women are victims, they view, many times, themselves as victims. Ask women on the street. Ask women who are getting ready to line up for grub at this particular time. They see themselves as victims, not only of the resources that have been provided but victims, also, of those resources which have not been provided.

Therefore, what we must do with those of us who are providing services for women, is view women in a different way. It is vital for us, if we are to respond in a germane way to women, single women, with children in our society, to begin to make sure that they have mobility.

For instance, I'll give you just one instance. A lot of women who come here have no mobility. They stay in one—in a single room dwelling where they have 3, 4, 5 children. In that one room there is no mobility. The only mobility they have is when they bring their children here, or they take them to the Y or other places, and then they go back to their rooms and they breathe a sigh of relief because, at last, in that one room, they can get up and move around in that place without being interrupted by the children.

Therefore, it seems to me that we have a challenge to deal with the feminization of poverty. The experts say to us that women and children—the feminization of poverty--that it will be, by the year 2000, the most critical problem that we face in urban America today. I am convinced that we are moving toward that.

Finally, just let me say that there is a third factor which we see, that we feed here, of those who have just recently lost their jobs. But we, very many times, don't even know, but tremendous resources of people who walk the street every day, who stand in unemployment lines, medical lines, housing lines, and hunger lines, tremendous resources of individuals, if given the opportunity to find a job, have a job, get a job, would, in fact, work.

Now, we are convinced that what we have done is explore that possibility, now, to take the ranks of those who can work from our lines, our food lines, and put them in jobs—mainly because the job market is there. Let me tell you something that we have done in San Francisco. We have set a precedent that no other city has done. We just recently finalized this program.

A block away from here the Ramada Inn is building a huge place for people who are visitors and people who would like to belong to our city. Before they concluded the architectural design, they came to us and said, "We want to get this plan through the planning commission of this city, and we know that you and others are going to oppose it."

And we said, "We are."

"How can we get this plan through?"

And we said, "We work on a self-interest basis. You've got self-interests, we've got self-interests. And how we respond is self-interesting. Let us tell you what we would like and you tell us what you would like." And we did that.

One thing, the first thing, that we asked them about was to make sure that the people of the Tenderloin did not have to move from this area. So, we entered into a plan of low-cost, rehabilitation housing with the Ramada Inn, where they have put money, now, into rehabilitating units in the Tenderloin. That has taken place and it is just about complete.

Second, we said to them, "We want out people in the Tenderloin who have the skills, who would like to get the skills, to be interviewed and to go through the process of getting a job. And we would like for 20 percent of them to get jobs at the Ramada Inn."

As of last Saturday, over 1,000 people have been interviewed. We have a commitment at this particular time for at least 20 percent of the people from the Tenderloin and from San Francisco to, in fact, get jobs at the Ramada Inn.

Third, we said to them, "Give us $50,000 a year to put back into our community, to provide services for the people of this community, so that we can continue to take care of those who really are underemployed."

They agreed to that, for 4 years. The agreement has been consumated and now we have two other hotels, we've just reached an agreement with them. And I would hope that the next time the Select Committee on Hunger comes here we will be able to say to you that the underemployed rates have decreased because of developers and community people working together.

Now, having said that, it is our conclusion that what we must do is find more favorable ways to take people from the ranks of the hungry, because we are convinced that they must have dignity and pride even when they stand there. But we must also try to provide for them some way out of a system that they are caught in.

Thank you. [Applause.]

Mr. PANETTA. Thank you very much, Reverend.

RESPONSES TO QUESTIONS FOR A. CECIL WILLIAMS

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Glide Memorial's food program serves three meals per day. At the present time, there are restrictions on who is eligible to receive breakfast and lunch, but dinner is open to everyone. Can you explain the need for the restriction on the morning and afternoon meals?

Answer. No response received.

Question. Would you cite specific problems that you might encounter in managing your program if you were to receive Federal support?

Answer. No response received.

Question. You spoke of an increase in the number of women and children coming to Glide Memorial for meals. Can you detail for which meals there is a larger attendance of women and children? Can you give us a rough percentage or figure of the number of your meals which go to women and children?

Answer. No response received.

QUESTION SUBMITTED BY HON. MARGE ROUKEMA

Question. Are you turning away any people who come to Glide Memorial Church for meals? If so, how many and why?

Answer. No response received.

[The prepared statement of Mr. Williams appears at the conclusion of the hearing, see p. 514.]

Mr. PANETTA. Father Lotito.

STATEMENT OF FLOYD A. LOTITO, FRANCISCAN PRIEST, DIRECTOR, ST. ANTHONY DINING ROOM, ST. ANTHONY FOUNDATION

Mr. LOTITO. Ladies and gentlemen, St. Anthony's Dining Room was founded in 1950. The concept of the dining room was that it was to be a sit-down dining room, a full meal, no questions, no sermons, no descrimination, but with recognition of the human dignity of each person. There was to be no financial support by the Government or by the church. The project was to be made possible by free-will offerings of food, funds, and personal services. And this concept has been retained for 34 years.

We saw in the very beginning that we could not just focus on a person's stomach, but if a person was sick, also to get a person out of the vicious cycle of poverty, we would have to have other services. So, we now have a free clinic, a free employment service getting jobs for people, a free clothing center, many programs for the elderly, especially the poor elderly in the Tenderloin, rehabilitation programs for men residents, for elderly ladies on a limited income here in San Francisco, a rehabilitation house and work program for men in the city, a special program of showers, laundermats, drop-in centers, and a night-time shelter for women and children.

A question that is always posed is: Who are the people coming to St. Anthony's Dining Room?

The elderly on a low fixed income, particularly those who are unable to stretch their funds sufficiently to cover food, shelter, clothing, and medicine for the month. And we notice that many of these people are now bringing jars with them so that they can extend what is given to them to some other meal.

The disabled—mentally or physically disabled—people. And many of these are the people who are victimized and who are taken advantage of.

The unemployed. Jobs are hard to find, especially in the city as we've heard.

The completely destitued—people who receive no income whatsoever, no general aid, no Social Security. They are also homeless.

People who were beneficiaries of programs which have been cut back or cut out, such as Food Stamp Programs, CETA Programs, SSI.

Women, children and families in distress. We are noticing more and more of them, including parents without jobs, runaway teenagers, babies with single parents.

Ever more numerous Hispanics from Mexico, Central and South America.

The hard core unemployable—mainly because of acute of chronic alcoholism or drug addiction; many are mentally or psychologically disabled, retarded, with no marketable skills, no education. Some of these people require adequate nourishment much more than others in need.

And possibly some abusers, people who take advantage of the free program. But most studies show that this is a very, very small percentage.

On just a cursory survey of people who come to the dining room, I found out that they come from every State in the Union and from many foreign countries.

My own research shows me that the nonpoor do not mix with the poor. The nonpoor would not stand in line for an hour waiting for something to eat or sit at a table with the poor.

St. Anthony's dining room is very much a socio-economic barometer of our society. We notice how the dining room reflects the economic condition, the unemployment. It reflects the social condition. So, we opened up, 34 years ago, October 4, and we served 150 people. Today, we're averaging nearly 2,200 hungry, needy men, women, and children. There has been a noticeable 30-percent increase in the last 3 years, shown by our daily record of free meals served. Our total since 1950 is over 16¼ million meals.

We help people in different ways, so certainly the first level is direct aid, giving people food, medicine, clothing, shelter. We realize this is an emergency, we realize this is taking care of the symptoms of the problem. We want to get to the causes, what is causing this problem. We realize, too, that if a person is hungry, we can't tell him to wait until we find out the causes and solve them.

The second level that we help people is rehabilitation. We have rehabilitation programs going on. We have job employment, where we try to get people jobs, where we try to teach them skills to get these jobs to make them ready for the jobs.

The third level is reconstruction, so advocacy, changing the causes, getting to the roots of why do we have poverty, why are people caught up in the vicious cycle of poverty, and how can we go about changing this.

With regard to the Government and the private sector, I think both of us have an obligation to help our people. Currently, it is costing us 66 cents to serve one meal.

Those that have copies of my report will find it in appendix 1 and appendix 2. And if you don't have copies of the report, I'm sure you can get it from Sala Burton's office; we can make copies of it.

My experience with Government programs is that it costs the Government many times that amount. It takes much more personnel that we have to accomplish what we do. People complain to me about their demeaning experiences with Government programs—inefficiency, bureaucracy, redtape. Some tell me that they get lost in Government rules and regulations, policies, and procedures. Many just don't have time, or don't fit into the pre-established category.

I think there is a connection between world hunger and what is going on locally, what is going on in the United States. I think one of our purposes in helping our people who, I think, are our greatest asset, is that we—I believe the poor should be enpowered and enabled to share in the control of the economic resources of their country. People need land, people need jobs, people need to be able to feed themselves. I think that we should enpower the people so that they become part of the decisionmaking that affects them.

I see a parallel here between the poor in our land and the poor in foreign lands. Here we try to persuade people, try to persuade the poor, to register to vote, and so enable them to become part of the decisionmaking that affects them and to gain some political clout, equitable political influence. We try to get them jobs so that they can enter the mainstream of society and take charge of their own lives. I don't believe our objective is to make people dependent; make them independent, in charge of their own lives. I believe that people are our greatest asset.

Yes, our people are. Here, how we treat our needy people—the poor, the disabled, the elderly, the unemployed—is how our country will be judged. I think there is a connection between bombs and butter. More funds and programs should be given for the development of people and not used for making wars and armaments. So many guests come up to me and say that they would like to get a job, to get out of the streets, to get out of poverty. Again and again I hear those familiar words, I want a job, not a handout.

One of the most cruel insults we can give to these people is not to acknowledge them, to say that there is no hunger problem in the United States or to label them all freeloaders. What an erroneous stereotype. I repeat: People are our greatest asset and this is how we will be judged. [Applause.]

Mr. Panetta. Thank you.

Responses to Questions for Floyd A. Lotito

QUESTIONS SUBMITTED BY HON. MICKEY LELAND

Question. Can you detail for us how your clientele has changed the past year? Are you finding that you have to restrict the number of single men receiving meals to make room for women and children?

Answer. We are seeing more women and children, more unemployed, more younger people, more disabled, mentally and physically. We are not restricting the number of single men receiving meals. So far we are able to handle all who come. Our numbers have increased; we have enlarged our dining room; we are open longer.

Question. Would you site specific problems that you might encounter in managing your program if you were to accept Federal support?

Answer. (a) Redtape, paper work;
(b) at the mercy of a program that can be cut back or cut out;
(c) being restricted; having dictates to follow;
(d) losing flexibility and independence;
(e) donors don't like to help Government support programs; and
(f) trusting entirely upon the Lord and the good will of people.

QUESTION SUBMITTED BY HON. MARGE ROUKEMA

Question. Are you turning away any people who come to St. Anthony's dining room for meals. If so, how many and why?

Answer. No, we are not turning away people for meals. So far we are able to handle all who come. Our numbers have increased; we have enlarged our facilities; we are open longer.

[The prepared statement of Mr. Lotito appears at the conclusion of the hearing, see p. 515.]

Mr. PANETTA. Mr. Gonzalez.

STATEMENT OF LOUIE GONZALEZ, URBAN AND PUBLIC AFFAIRS MANAGER, SAN FRANCISCO DIVISION, SAFEWAY STORES

Mr. GONZALEZ. Yes. Thank you for asking me here today to speak on the subject of hunger.

Just to give you an idea of the territory which I cover, so you can get an idea of the broad experience I've had in looking at this problem, I cover a territory of four Western states: California, Arizona, Nevada, and Hawaii. And oftentimes when I talk to people in feeding programs and food banks, one of the things that keeps coming up is the fact that their clients, the people who come to them in times of need, is increasing, it is not decreasing. And despite the fact that you hear on the radio and you read in the newspaper that the economy is getting better, for some reason at that level it doesn't seem to be getting better.

Just to give you an idea, we have been in the business of selling groceries for almost 60 years. And in the time I have been in Safeway, 4 years ago, we did not receive the amount of donation requests or asks for assistance of food programs to the degree that we do now. On an average day—and I'm exluding holiday periods—we receive between 30 to 45 requests for donations. During a holiday period that may go up as high as 90 to 100 a day. And what's interesting is that these are all for food programs, they are not just for general assistance. They are asking specifically for food.

What is also interesting is that in the Bay Area and in San Francisco there are many churches, and what has happened is that most of those churches have begun feeding programs; not because of an idea that they want to get into the feeding program, it's a necessity for them. There are people who go and attend those churches who need the help.

In States where we have operated—and in part of my attachment I listed the number of food banks, specifically, that we have helped—currently we are supporting 118 food banks in the States in which we operate.

We have a three-tier system of donations. We have food banks and feeding programs, we have our donations program which is sending gift certificates and cash; two, requests; and last, those stores that help programs in their immediate neighborhoods. Those are three separate programs that we try and maintain in order to match the problems that are occurring in the neighborhoods.

As Reverend Williams pointed out, one of the things that he experiences is that immediately within this community he is well aware of what is going on. If there is a problem economically in the community, he immediately hears about it. On the other end, we as a food business immediately react to what is going on in the community.

For example, several years ago a large auto plant closed down, literally overnight, and it put practically 10,000 people out of work. We happened to have our office next door to that, and within 1 day we had requests from 10,000 people to help support them. We had proposals that said, would you help us by giving us free groceries for at least 6 months? Would you help us by giving us a discount of at least 25 to 30 percent on the groceries that we purchase in your stores?

That was one industry. There have been several other industries that have collapsed since then, and the same type of requests coming in.

One of the interesting things that I think you should be aware of is that the general public does not really know what is going on in terms of hunger in the United States. One of the interesting things is that they don't know what food banks are. They don't understand what Reverend Williams goes through or what St. Anthony's goes through at Thanksgiving or Christmas, or why they have to feed several hundred thousand people, they don't understand.

We try to do our part by letting the people know that there are these programs available. We have our grocery bags, and to most people grocery bags are something they put their groceries in. We try to provide it as a community service, where we put information on the bag. Last year we put out a grocery bag with the imprint explaining what food banks are, that reached 72 million people. That was one part of what we try to do.

Most of the companies in the bay area try to assist on various levels. When I called around to prepare my statement for today, I asked companies that are involved in various feeding programs, What do you do?

And one company, for example, McKesson, I called, I asked, "What do you do?" And they told me that, "Well, just recently we gave a large donation to the San Francisco Food Bank to help them in their warehouses, to help them get refrigeration." They've also donated refrigerator trucks.

We also lent technical assistance to make sure that the food was moved efficiently. One of the things you have to remember is that when you're moving food to these programs, this is not canned goods, it's not packaged goods; it's highly perishable, and hours can mean the difference between the food that they receive today and the food they're going to supply tomorrow to feed people with, because what they receive today may not last until tomorrow.

What is nice about food programs, and especially in San Francisco and the bay area, and all over the country that we participate in, is that if we have food that is ready to be donated, we can call them. They will pick it up, and I know that once I have made the call, I don't have to worry about it anymore. Because I know the food is not going to be wasted, it is going to reach the people that need it.

One of the final things I would like to—you know, you've heard a lot of proposals, you've heard a lot of ideas here today; I'm sure you're going to hear more as you go around exploring this subject of hunger. One of the things I'd like you to remember is that there are many, many programs in place, currently being utilized, that are officially trying to address the hunger that is going on in the United States, the waste of food that is going on at all levels—not just at supermarkets but at the food manufacturing level—and they're trying to do something about it. And I would hope that in policies that you put together, that it is not going to destroy or lessen the efficiency that is currently being met, that there can somehow be a consolidated effort to use all programs that are there, take the ideas that you've heard, and make sure that everyone works together.

Because there is nothing worse than having programs that are currently working well and then bringing in new policies and saying, "there are new regulations," and then, unfortunately, could not meet those policies and regulations, and, therefore, it should go out of business. I've seen it happen. I've seen it happen in cities and counties where they've put in new health regulations that jeopardize feeding programs because they don't quite come up to the standards that are being proposed by the city and county.

And I would hope that in the policies that you put together, you address those types of things; because Reverend Williams could be put out of business, literally, by new Federal policy that would knock him out; St. Anthony's Dining Room could be put out of business because it does not quite meet the regulations that are being put up before the States.

In my business we are highly regulated. We have to meet regulations and we understand the need for them. But in Reverend Williams' case and St. Anthony's Dining Room's case, they are not regulated, they are churches and they are there to help the people when they are in need. We are in the business of selling groceries, but we're there when they're ready to help other people.

And I would hope that would at least get the message across. Thank you very much. [Applause.]

Mr. PANETTA. Thank you very much.

RESPONSES TO QUESTIONS FOR LOUIE GONZALEZ

QUESTIONS SUBMITTED BY HON. BILL EMERSON

Question. Please describe what you have found to be the relationship between retail food stores and private food programs? Is it a cooperative venture of long-standing? To me it seems to be a logical marriage between two vital parts of our communities—private enterprise and private charities.

Answer. The relationship between retail food stores and private food programs has been excellent. The cooperative venture began between the two in the early 1960's when several community organizations, nationally as well as Safeway and other large corporations, met to discuss food waste. From these meetings the concept of food banks and Second Harvest was born.

Because foods that are distributed through the food banking system and other private food programs are perishables and require rapid distribution—produce, cheese, butter, etc.—public/private relationships must be extremely cooperative in order to efficiently handle the products.

This relationship is constantly being evaluated and critiqued in order to prevent problems and solve logistics of distribution before major situations can arise. In this way, the private enterprise—private charities can forge a partnership of true cooperation that will be able to handle any situation.

Question. Can you describe your store's nutrition education efforts? Do you think these reach low-income shoppers?

Answer. In February 1983 Safeway launched a national nutrition awareness program designed to provide consumers with nutritional information they want at the point of purchase. Our Safeway Nutrition Awareness Program called S.N.A.P. gave our customer some information about the foods they eat in an easily obtainable and useable form. It includes a bimonthly magazine, Foods Unlimited, which gives general food information, feature recipes with caloric and nutrient breakdown and answers to some customer questions.

Also included are nutrition awareness pamphlets covering specific nutrition topics. These topics include sodium content of foods and how to decrease your salt intake, sample meal and snack menus for children under 5 and how to make mealtime happy for them.

All of this information is free and available to the more than 3 million people who go into Safeway's 1,900 U.S. stores daily. We feel this information reaches all of our customers and because of the popularity of the program, nutrition programs by schools, churches, universities, and registered dietitians have begun to request and distribute S.N.A.P. information. It has been a very successful program.

[NOTE.—Material referred to retained in committee files.]

[The prepared statement of Mr. Gonzalez appears at the conclusion of the hearing, see p. 520.]

Mr. PANETTA. Mr. Gonzalez, how much does Safeway contribute to food banks? How much do you estimate?

Mr. GONZALEZ. Last year alone we contributed over $2 million, and that would be approximately 3 to 4 million pounds of food. That is just to food banks; mind you, that is not feeding programs or any of the other programs that we do, that's just food banks.

Mr. PANETTA. Do you have an overall number of what you contribute to various feeding programs?

Mr. GONZALEZ. No. But I would estimate that it would be closer to about $4 to 5 million.

Mr. PANETTA. Is that running about the same level for 1984?

Mr. GONZALEZ. No. It's actually over—up; in 1984 it's up over 1983.

Mr. PANETTA. You are involved as a board member for the Santa Clara Food Bank?

Mr. GONZALEZ. That's right, and also lend technical assistance to three other food banks in the bay area.

Mr. PANETTA. How many kitchens are supported by that food bank?

Mr. GONZALEZ. I believe approximately 30 to 40.

Mr. PANETTA. Do you have an estimate as to how many people are served by each of those or maybe overall? Could you give me an estimate as to——

Mr. GONZALEZ. The estimate would be between 150,000 and 200,000 people. That is just that one food bank.

And remember, that they are asking about kitchen programs. That is not the entire bulk of their programs. So, they are 150,000 to 200,000 people.

Mr. PANETTA. Can you give me an idea of what it looks like this year?

Mr. GONZALEZ. This year it's running, or probably running, about 15 or 20 percent up over 1983.

Mr. PANETTA. Over 1983?

Mr. GONZALEZ. Over 1983.

Mr. PANETTA. How long have you served in the food bank capacity?

Mr. GONZALEZ. Myself or the company?

Mr. PANETTA. Yourself.

Mr. GONZALEZ. I've been in food banks for 4 years.

Mr. PANETTA. Four years?

Mr. GONZALEZ. Yes.

Mr. PANETTA. Could you give me an idea, over the 4 years, what——

Mr. GONZALEZ. What has changed in the 4 years?

Mr. PANETTA [continuing]. What has changed?

Mr. GONZALEZ. I would say that probably in the 4 years that I've been involved with the food bank, the demand for their services has tripled, simply because—Remember, Santa Clara took the brunt of the several major industries that closed in the area, and consequently they—they may be an extraordinary case, but I've seen their client load and the demand on their program for at least 300 percent. And there are times—in fact, they've moved to a new warehouse just to accomodate the demand. Because remember, one of the major necessities of a good food bank is a good warehouse, because you have to be able to distribute the food quickly. When they receive a donation, they receive the food into their warehouse, they break it down according to their membership needs, and then they call the membership member to pick it up. And it's got to be done very efficiently, otherwise the food's just wasted.

Mr. PANETTA. Is it fair to say that the problem, as with Father Lotito and Reverend Williams, that over the period that you've been working, you've seen a tripling as well?

Mr. GONZALEZ. Oh, yes. Absolutely.

Mr. PANETTA. I'm addressing it to both Reverend Williams and Father Lotito.

Mr. LOTITO. Yes. Statistically, as I said, it's 30 percent in the last 3 years, so we were serving 3 years ago, 1981, an average of 1,700 a day. We're now serving nearly 2,200 a day. I believe 2 months ago it was over 2,300 a day.

Mr. WILLIAMS. We have seen it triple, also.

At this point, as reported by the Department of Social Services, 800 of people who come to Glide are paying the Government social service, GA assistance. Their food is paid for. We feed about 3,000 people per day, three meals a day. We have seen a tremendous increase. Two years ago it was nothing. At this particular time we've had a great increase, up to close to 3,000.

Mr. GONZALEZ. Also, I would like to point out that one of Reverend Williams' programs does feed three meals a day. In those programs that I am aware of, where they used to feed three programs a day they've cut back to two, simply to accommodate the numbers; because they can no longer sustain three meals a day.

Mr. PANETTA. Mrs. Roukema.

Mrs. ROUKEMA. I interpret what you said about the 30 percent increase and the tripling, would be the consequence of benefits running out.

Is that what you were suggesting, the benefits have run out? Because when a plant closes there are unemployment benefits, there are union benefits, there are savings, too. But let me ask that question and another for clarification, because I think it's awfully important for us to understand why this takes place. There's no question about feeding the hungry, but getting at the underlying problems and the reason for the growth is another question.

And for clarification, I think you said that the day after the auto plant closed you had requests. And I don't understand that, because auto workers are among the highest paid, they have 2-year benefits from their unions, and many a plant closes, as I understand it.

Can you explain that? I want to understand the dynamics of it.

Mr. **GONZALEZ**. I can, because that was one of the questions I asked——

Mrs. **ROUKEMA**. Sure, I understand.

Mr. **GONZALEZ** [continuing]. As to why we also had the same occurrence here in the Bay Area, when the air traffic controllers went on strike.

One of the reasons was that it was not a simple layoff situation, it was a complete closing down and walking away from that plant. And what they saw was 2 years of benefits that they had to extend out over an unknown period of time. And looking at that, they panicked. They said to themselves, Yes, I've got X benefits but I've got to make it stretch because I have no marketable skills, there are no auto plants anywhere near here. I have looked for work in other areas. The Ford plant also closed down.

Mrs. **ROUKEMA**. There was definitely a recession. That was part of the factor?

Mr. **GONZALEZ**. Well, it's either the recession or the fact that the auto industry decided to close down its Fremont plant.

Mrs. **ROUKEMA**. Do any of you gentlemen have the information—I asked the other panel and they didn't seem to know—what the unemployment rate presently is and how it is compared to a year ago?

Mr. **WILLIAMS**. I'm sorry. I was reading a note and I didn't hear the question.

Mrs. **ROUKEMA**. We'll get to that. But I guess I just have to say God bless you gentlemen for the soul work that you're doing. God bless you.

Mr. **PANETTA**. Mr. Leland.

The **CHAIRMAN**. I have one further question. First I would like to say to Reverend Williams, thank you again for this opportunity. I appreciate the work that you are doing.

Let me ask, Mr. Gonzalez, how many other food store chains are involved in this effort.

Mr. **GONZALEZ**. Well, you know, there are many, many different levels of food chains. We would like to see more. There are probably one or two other major chains that are doing what we are doing, but not to the extent that we are doing it.

Mr. **WILLIAMS**. Also, I just want to add that not only do they serve food banks, but again, let me emphasize, that in regards to food programs I get, for instance, direct service from Safeway at times. It's all who you know and how you do it, you know. That is direct services.

Mr. **GONZALEZ**. To answer your question, we try—you know, my colleagues and I in the private sector—we do meet and talk about this. And we have held lunches on behalf of the food banks, food programs, trying to get other companies to come on board. It is not something that they see as a necessity, because, for example, the food manufacturers and other types of food brokers and what not are looking directly at just selling the product, and they don't see, necessarily, the other side of the coin. We, on the other hand, see both, because we buy as well as sell and we also see the tremendous need for it.

Mr. **PANETTA**. Mr. Emerson.

I'd just like to comment, I'd just like to say, Mr. Gonzalez, that if you had a job in the Government it might make some sense to provide some incentives, at least tax incentives, for those companies like your own.

Mr. GONZALEZ. Now, there are tax incentives. There are tax incentives available for companies that do utilize the donation programs. However, many companies choose not to.

Mr. PANETTA. Mr. Emerson.

Mr. EMERSON. I just want to thank you all very much for the fascinating testimony. I'm sure we'll be drawing on it for a long time to come.

Mr. PANETTA. Mr. Fazio.

Mr. FAZIO. Since we are here with Father Lotito and Reverend Williams, who provide so much of the food to the community, and, in some cases, from the Federal food banks——

Can you tell us quickly what we can do better in the distribution of our excess commodities?

Mr. LOTITO. Make them available to us.

Mr. WILLIAMS. Yes. I think when he said make them available, because, you see, we get them maybe at one time, and we're told that something else will be coming 3 months from now, and we don't see it. And we have a commitment to the people by saying to them, Look, expect something in 3 months, and then we don't get it. That's part of it.

Then, one other thing: It seems to me that it is vital to remember—I didn't know that cheese was as important to people until it came our way and we began to distribute. And all of a sudden I realized how important cheese is to people—and butter and other very important staple foods that people need. Keep it coming. I think that is the important thing—I want to end on a consistent basis—rather than every once in a while.

Mr. GONZALEZ. Also, what is interesting, I know of one experience where—we keep talking about the regulations—you know, we are required by law to sell certain types of produce, for example a certain grade. There was a case in the East Bay where a food project had an ability to actually get from a local grower undersized oranges. The USDA said that that could not be given away because it was undersized, and to actively plow it under simply because it was regulation. And that food was certainly edible.

They decided to violate the USDA not to distribute the food, and they went ahead and did it anyway, much to the chagrin of the USDA. Of course, they got themselves in a bit of a legal hassle there, but at the same time the food did get to the people. But there was an immediate question about donated undersized fruit to the people.

Mr. PANETTA. Mr. Morrison.

Mr. MORRISON. Gentlemen, I have a question for Mr. Gonzalez. One of the points that has been made is that supermarkets are fleeing from the inner city taking with them the opportunity for inner-city residents to purchase at better prices—is there any industry attitude on this?

I know you have to go where the dollars are, you are in private enterprise, and we need you alive and well. But is there any sort of tax incentive or urban enterprise zone or something that we could do that would encourage you to stay within that inner city?

Mr. **Gonzalez**. At this point I would say there are several things that you could do.

One of the reasons that—remember that the outgrowth of the supermarket industry began in the 1950's with the large what they called supermarkets. Before that it was neighborhood grocery stores. And in the last several years, what has happened is the concept has gone further in that the larger stores. And I'm saying very large stores; 50, 60, 70,000 square foot stores are not unheard of anymore. That is the trend of the supermarket industries, to go to the larger store to provide all of the things that you as a consumer want to find in a grocery store.

What is happening at the same time is that there's been a movement away from the inner city to the suburbs. It's coming back slowly, but at the same time it's gone out. With that has gone grocery stores. In the cities where we've closed stores, if you've looked at the trend where—if you've looked at what we had 10 or 15 years ago in the amount of square footage that was available at that time, today we probably have more square footage than we had 15 years ago in newer facilities.

One of the things—we try to explain this—a facility has a life span of about 20 years. And I'm not talking about the building, itself. What has happened in the last few years is, for example, utilities have gone skyrocketing out of sight. If you have an old facility, it is not even possible to insulate it for energy efficiency. What happens is you either have to tear it down and build a new one or even build a new store. That is one.

The other one is, what has happened in the inner city is that landlords, the people who actually own the building and the land, always look at highest and best use. And what's happened is that supermarkets are not highest and best use anymore. I mean, if you can put in a high-rise building, retail, commercial or condominiums, on the same site, suddenly what is happening is, the value of that property has skyrocketed 10, 15, 20 times, much more so than a single-use grocery store.

Mr. **Morrison**. Let me ask one other question.

You've gone to generic brands.

Mr. **Gonzalez**. We haven't, but other chains have.

Mr. **Morrison**. OK, you have your own generic brand.

Mr. **Gonzalez**. We have our private label. [Laughter.]

Mr. **Morrison**. That is understandable. My wife buys some things that aren't advertised, and the price is better and the quality seems as good.

As a farmer, I become concerned with the fancy add-ons to basic food items and the increase in price because of packaging, preparation, and precooking. As we look at stretching the nutritional value that food stamps can buy, I wonder if we are giving consumers the opportunity to choose.

Is there any way that we can possibly begin to section the store or move back to some basic commodities that would tie in with our nutritional training in here's what's good for you type things, all of which would certainly make the Federal and State food programs go further?

Mr. GONZALEZ. You bring up a good point.

Oftentimes, the product you buy, most of it is packaging—you are paying for the packaging. The trend in the industry, for example, is to go more toward the natural foods, the bulk foods, and you buy specifically what you need, and you're not buying the packaging that goes with that. What is happening across the country, and it is coming to California that we can tell, is that State health departments, local health departments, are seeing it's not sanitary. You can't do that, because what is happening is we want to see sterile, packaged foods.

So, what they're saying is, You can't sell these things.

And we're saying, But why? Because the consumer is going to buy exactly what they need.

If you want to buy 2 or 3 ounces of sugar, why should you buy 5 pounds, when you don't need 5 pounds? But what's happened is they're saying you can only buy the packaged good.

We're trying to fight—we as an industry are trying to fight—and say, This is something the consumer wants. But the consumer, at this point, has not—it has not reached the critical stage with the consumer saying, Yes, we want this and this. And there's been no movement to change the regulations.

You have the power to do that. You can address that address and say, Why can't we relax that sort of thing and give the consumer the option? That is one of the things we tell everyone, is that the consumer has the option to buy what and where they want, by emphasis of the consumer dollar. And if they want to do it with food stamps, in the field, in Gilroy or in Salenas, they can do so. If they want to buy in the middle of downtown San Francisco, the Safeway store, they can. If they want to go to a cooperative, if they want to go to a food bank program, they can. That's the choice of the individual. And we believe in this.

Mr. MORRISON. Thank you, Mr. Chairman.

Mr. PANETTA. Mrs. Burton.

Mrs. BURTON. I want to thank you gentlemen. I also want to thank Reverend Williams for making it possible for us to meet here. I have a question and we are running out of time.

What percentage of the people that you feed at St. Anthony's as well as Glide, are refugees?

Mr. LOTITO. There is a percentage. I see them much more often in our clinic. In fact, we have a specialized clinic just for the refugees, and for them coming in and for families and for children. So, we have large numbers there participating in our St. Anthony Free Clinic. I see them, also, in the dining room, but not in as great a number as in the clinic. Culturally, they do things together as a family, not as a single person. So, sometimes we'll see a whole family of children with a surrogate parent, an older one that will come with them. So, it is the clinic where I see the most dramatic evidence of it.

Mr. WILLIAMS. The Tenderloin is rapidly becoming full of new refugees. And one of the things we've noted, for instance, the senior citizens of the new refugees come here to eat, a sizable number. I would imagine that we are now—at one time we only had about 10. In the span of the day we may feed as many as 200. We don't see young people. We're seeing children, however, who are becoming a part of our children's program, now becoming a part of a new food program that is beginning to increase.

Mrs. **Burton**. As a San Franciscan I am very proud of the two of you.

I'm very proud of you, too, as a Californian, Mr. Gonzalez. Thank you.

Mr. **Panetta**. Thank you, members of the panel. We appreciate your taking the time, and, again, providing us with this information.

Now, let me say to all those that are here, that the record will be open for 3 weeks, both for those members of the panel of the task force to submit questions and responses and, of course, anyone else that may wish to submit testimony for purposes of the record.

It is basically, I might say, the same story, whether we've been in Cleveland or Birmingham or Los Angeles or Chicago or Miami or Mississippi or San Francisco; it is the same story. And I guess the lesson of it all is that the time for talk is over, the time for action is here. [Applause.]

And we thank you.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. MARGE ROUKEMA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

I am delighted to be here today in this beautiful city. The majesty of San Francisco is always an unforgettable sight.

I represent a congressional district which lies on the exact opposite coast from here. My reason for coming to San Francisco is an issue which tragically, does span the breadth of our country, the problem of hunger. Tragically, hunger in America is not isolated to any one region or State or county or city. Nor is it a new phenomenon. What we need to do is devise ways of alleviating this problem.

Our select committee is here as part of its ongoing investigation into the causes and manifestations of the hunger problem both in the U.S. and overseas. We have already visited a rural area in Mississippi to examine the problem from that perspective. We are here today to hear how the specter of hunger affects people in urban areas. We are also here to learn how well our current programs are doing their job to combat the problem and how they are working. Are they meeting their intended purpose? Should some changes be made? What has been overlooked? What is going well?

As I have stated before on many occasions, my major interest in the issues before this committee is to try and discover why we still have hunger in a country as rich in resources as ours is.

This perplexing problem, which I call the "Paradox of Hunger," continues to astound and trouble us. Somehow, it should not be that difficult to get our excess production to every person who needs or wants it, but obviously it is. Why does the problem continue to get ahead of our capacity to solve it? Why, with all our resources, can't we better match the supply and need?

One major question we are examining today is why does hunger persist while we, as a nation, continue to produce more and spend more money on food assistance? At all levels of government, the benefits of our natural bounty and invention are made available to the hungry and the homeless. How effectively are we doing this is one of the topics our witnesses will address today. However, we forget the magnitude of our Federal Government efforts in this area, I point out that in 1983 the Federal Government distributed almost $20 billion in food assistance, up from $14 billion in 1980. This is not an insignificant sum. It covers a wide ranging number of aid programs that affect all segments of society.

Most importantly, assistance to combat hunger is not only a responsibility taken on by the Federal Government, as we shall hear later today. Local efforts play a key role, and I particularly single out the voluntary and private sector initiatives in this regard. We meet today in a setting where private aid is vital to the well-being of thousands daily. And efforts here in San Francisco carried on by private corporations have proved invaluable to the city's population.

The spirit of private charitable giving is very vibrant here and I look forward to learning more about these experiences.

We will also hear today about the relationship between good health care, proper nutrition and an attack on hunger. These considerations are obviously intertwined, especially when people are living at or below the poverty line. This morning we visited an example of one of our most succesful federally supported programs to assist in this area, the WIC Program. As a member of the Education and Labor Committee, which has legislative authority for this program, I am well aware of the success this program has had in aiding infants, preschool children and pregnant and nursing women with nutritious foods given at a crucial stage of development. A nutritious diet throughout one's entire life is also a key to combatting hunger and malnutrition among all age and income groups. I hope we will learn more today about the impact of nutrition on growth and ways in which people can be made aware of this relationship through various education programs.

Tragically, the problem of hunger in the U.S. is not a new issue for us today. It has been with us for far too long. This committee is seeking new ideas to combat it and we are eager to contribute proposed solutions. I thank the witnesses for coming here today and look forward to their productive testimony. We hope to hear some concrete suggestions to aid us in this task.

PREPARED STATEMENT OF HON. SALA BURTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, my colleagues on the committee, ladies and gentlemen, I would like to thank representative Leland and the members of the committee for conducting this hearing. I am very pleased that you have come to San Francisco to hear from some of the men and women who are closest to the problem of hunger in our society and who, in some cases, have dedicated their lives to eradicating it.

The Select Committee on Hunger has a dual focus—hunger in the world and hunger in our own country.

Clearly, our Nation must take a more direct and active role in reducing the appalling toll of hunger in Africa and in other parts of the world.

It is equally clear that our Nation, with abundant resources and a level of affluence unmatched in the history of the world, can no longer tolerate hunger in our midst.

I have chosen to be a member of our Subcommittee on Domestic hunger in order to participate in this process of obtaining the testimony of the many Americans who can document the continuing blight of hunger in our country.

Although our committee's mandate is to report on hunger rather than to prepare legislation, I believe the work we have embarked on is an essential element in the process of eradicating hunger in this land. I am proud to be a part of this effort, and I want the people of this city and this country to know that I shall do all within my power to see that no man or woman and especially no child shall ever know hunger again.

PREPARED STATEMENT OF HON. BILL EMERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Thank you Mr. Chairman. I am pleased to be here in San Francisco for the second hearing held by the domestic task force of the Select Committee on Hunger. I want to express my thanks—and I am sure the thanks of the other Members of the Select Committee—to Congresswoman Burton for her invitation and assistance to the Select Committee in planning this hearing.

As some of you may know the Select Committee on Hunger was established earlier this year by the House of Representatives to review the issue of hunger, here and abroad, and to make recommendations to the standing Committees as to any legislative changes that are warranted. Chairman Panetta and I both serve in these same capacities—Chairman and Ranking Republican—on the Subcommittee with jurisdiction over several food assistance programs, one of which is the food stamp program. We have held hearings this year and last across the United States, reviewing this same issue. As a result of the Subcommittee's activities a bill—H.R. 5151, The Hunger Relief Act of 1984—will be taken to the House floor in the near future—in fact it is scheduled to be taken up this week.

This bill makes several changes in the food stamp program, most of which were recommendations of the President's Task Force on Food Assistance, H.R. 5151:

1. increases food stamp benefits in 1985 and in 1986 and requires an indepth review of the thrifty food plan, the basis for food stamp benefits;
2. assures that the homeless who are eligible for food stamp benefits can have access to the program;
3. requires states to assess the hours of operation of food stamp offices to insure the working poor have access to the program;
4. increases the work expense deduction from 18% to 20% of earnings and increases the shelter/dependant care deduction from $125 per month the $155 per month;
5. improves the job search provisions of the food stamp program by giving states broader flexibility to design job programs in which individuals can get and keep jobs; and,
6. improves program accountability by increasing penalties for those states not reducing the rate of error to 5%. Increased penalties would be collected in fiscal year 1987.

These are some of the provisions of H.R. 5151, which was designed to address the needs of individuals relying on the program and to make the program more effective and efficient. I commend Chairman Panetta for his work on this bill and I enthusiastically support H.R. 5151.

As we begin our hearing today it is my belief that many of the problems we saw this morning and the testimony we will receive will reinforce the need to see H.R. 5151 passed.

One day cannot give us a clear picture of what is going on in San Francisco or any urban city. That is why we must rely on both the witnesses we will hear from today and the experience gathered from our earlier hearings. We do know what is available from the federal government to help the needy. The food stamp program cost a total of $12.8 billion in 1983—a 40% increase over the amount the program cost in 1980, just a few years ago. Child nutrition programs—school lunch, school breakfast, special milk programs, child care food programs—provided benefits of $4 billion in 1983. WIC benefits totalled $1.2 billion, up from the $736 million figure in 1980. Elderly feeding programs provided $116 million dollars and over $1 billion of surplus commodities were distributed last year.

In addition, according to Giving, USA Americans donated an estimated $60.39 billion to hundred of thousands of charitable organizations, institutions and agencies, some of which provided food to needy people both here in California and across the United States. States and local governments also provide assistance to the needy through the Aid to Dependent Children (ADC) and Medicaid programs—which have a shared funding with the federal government—emergency assistance, general relief assistance and other local and state assistance programs. Many Governors and Mayors have set up a structure—a panel—to assess the hunger situation within his or her state I will be interested in hearing of the California actions in this regard.

My point in briefly reviewing the programs available is to let you known that we are here to learn about California and San Francisco. If these programs are not working we need to know. If the benefits are not adequate, we need to know. If housing is substandard, we need to know. If medical assistance is not sufficient, we need to know. However, you need to know that solutions do not all rest with the federal government—many issues must be resolved at the state and local level. I believe that many of the solutions to federal programs will be found in H.R. 5151.

I am anxious to hear from our witnesses this afternoon and what they propose should be done.

Thank you Mr. Chairman.

USDA FOOD ASSISTANCE PROGRAMS

[Dollars in millions]

Program	Date of enactment	1980 budget	1983 budget
Food stamps	1962	$9,191	$12,830
Child nutrition:			
School lunch	1946	2,104	2,354
School breakfast	1966	250	341
Special milk (commodities for school programs, including bonus)	1955	157	20

USDA FOOD ASSISTANCE PROGRAMS—Continued

[Dollars in millions]

Program	Date of enactment	1980 budget	1983 budget
		944	867
Summer food	1969	89	99
Child care food	1968	214	332
Nutritional supplements for women, infants, and children:			
WIC	1972	736	1,160
CSFP	1969	22	33
Elderly feeding	1965	72	116
Commodities donations:			
Needy families	1936	34	45
Charitable institutions	1973	70	192
Special food distribution	1981		1,038
Total		13,883	19,427

Source: U.S. Department of Agriculture.

USDA FOOD ASSISTANCE PROGRAMS—PROGRAM LEVEL OBLIGATIONS IN CALIFORNIA

[Dollars in millions]

Program	Date of enactment	1980 program level	1983 program level
Food stamps	1962	$563	$795
Child nutrition:			
School lunch	1946	195	227
School breakfast	1966	33	41
Special milk (commodities for school programs, including bonus)	1955	12	1
Summer food	1969	71	69
Child care food	1968	14	31
Nutritional supplements for women, infants, and children:			
WIC	1972	55	98
CSFP	1969	1	1
Elderly feeding	1965	6	9
Commodities donations:			
Needy families	1936	1	60
Charitable institutions	1973	4	17
Special food distribution	1981		6
Total		963	1,365

Source: U.S. Department of Agriculture.

CALIFORNIA

[Data in thousands]

	Participation [1] (average)	Free	Meals reduced	Total	Cost
School lunch:					
Fiscal year:					
1980	2,008	170,749	24,866	332,453	[2] $209,745
1981	2,037	183,881	25,740	333,375	[2] 230,708
1982	1,767	176,266	22,091	294,271	[2] 218,137
1983	1,758	183,332	21,547	300,072	[2] 240,986
School breakfast:					
Fiscal year:					
1980	388	56,092	3,946	67,434	35,115
1981	433	61,872	3,803	74,535	41,102

CALIFORNIA—Continued

[Data in thousands]

	Participation [1] (average)	Free	Meals reduced	Total	Cost
1982	362	57,286	2,538	64,115	39,384
1983	352	59,559	2,321	65,517	43,083
Child care:					
Fiscal year:					
1980	55	21,732	4,771	32,547	[2] 15,557
1981	82	45,456	4,396	54,228	[2] 29,338
1982	94	37,680	6,523	52,374	[2] 27,289
1983	98	42,093	6,545	57,409	[2] 31,408
Summer food:					
Fiscal year:					
1980	189	9,441		9,441	[2] 10,164
1981	163	8,222		8,222	[2] 9,806
1982	158	7,379		7,379	[2] 9,723
1983	159	7,590		7,590	[2] 10,331
Special milk (Half-pints):					
Fiscal year:					
1980		16,693		131,822	10,753
1981		17,744		118,290	8,097
1982		760		15,760	1,503
1983		699		13,153	1,277
WIC:					
Fiscal year:					
1980	133				55,087
1981	143				64,546
1982	163				80,103
1983	187				96,678
Food stamps:					
Fiscal year:					
1980	1,492				527,322
1981	1,605				604,304
1982	1,651				585,956
1983	1,786				741,897

[1] Monthly averages are 9 months for school lunch and school breakfast; 12 months for WIC and food stamps; and quarterly for child care. Summer food data are peak participation.

[2] Cash reimbursement cost only. Does not include commodities, cash-in-lieu, non-food assistance (child care in fiscal year 1980–81) or sponsor administrative costs (child care).

Data source: U.S. Department of Agriculture, Washington, DC.

CALIFORNIA WIC PROGRAM FACT SHEET

	Average participation	Average food cost	Average administrative
Fiscal year 1984 (through April):			
California[1]	209,277	$36.61	$8.09
Nation	3,033,070	30.84	7.07
Fiscal year 1983:			
California	187,237	36.07	6.69
Nation	2,536,965	29.61	7.25
Fiscal year 1982:			
California	163,296	34.22	6.59
Nation	2,189,031	28.73	7.34
Fiscal year 1981:			
California	142,891	31.50	6.14
Nation	2,117,853	27.86	7.08

[1] (Estimated for April 1984)

Source: Department of Agriculture.

CONGREGATE MEALS AND HOME DELIVERED MEALS

	1980		1983	
	Number of meals	Federal dollars	Number of meals	Federal dollars
Congregate meals (U.S.)	131,993,378	267,300,000	145,051,016	317,492,670
Congregate meals (CA)	11,705,469	24,154,879	12,273,588	29,200,151
Home delivered meals (U.S.)	36,396,921	49,500,000	57,518,472	62,025,000
Home delivered meals (CA)	1,823,274	4,473,126	3,383,564	5,704,507
Congregate meals (San Francisco)	690,509		1,074,109	
Home delivered (San Francisco)	45,221		320,540	

Source: Administration Aims.

ADDITIONAL STATEMENT OF HON. BILL EMERSON

Mr. Chairman. Fraud in the food stamp program is not the issue—waste and mismanagement are. $900 million a year goes to people who are either ineligible or receive too many food stamp benefits. Simultaneously people receive too few food stamp benefits through error. States must improve administration of the food stamp program and H.R. 5151 contains a provision to address this problem.

Additionally, I would like to mention the issue raised concerning the change that 3 million children have been cut from the school lunch program. There are fewer children in the school lunch program; but this has resulted from (1) an overall decline in school enrollment of about 4 percent; (2) eliminating private schools that charge tuition in excess of $1,500 annually; (3) new income eligibility criteria for free and reduced price lunches; and (4) verification of a family's income.

In fact, there are more children receiving free lunches now, 10.5 million, than in 1980—10.0 million. Any student from a family whose income is at or below 130 percent of the poverty level, $13,200 for a family of four, may receive a free lunch. Any student from a family whose income is between 130 and 185 percent of poverty, $18,800 for a family of four, may receive a reduced price lunch.

CALIFORNIA STATE PLAN FOR MANAGEMENT OF THE NUTRITION EDUCATION AND TRAINING PROGRAM

1984 Amendment

APPROVED BY:

Gene White, Director
Child Nutrition and Surplus Property Division

Gilbert R. Marguth, Deputy Superintendent for Administration

Bill Honig, State Superintendent of Public Instruction

California State Department of Education
1983

STATE PLAN FOR MANAGEMENT
OF THE NUTRITION EDUCATION AND TRAINING PROGRAM
1984 AMENDMENT

Prepared by

Nutrition Education and Training Program
Office of Child Nutrition Services

CALIFORNIA STATE DEPARTMENT OF EDUCATION
Bill Honig, Superintendent of Public Instruction
Sacramento, 1983

AN EQUAL OPPORTUNITY PROGRAM

The Nutrition Education and Training Program of the U. S. Department of Agriculture is available to all individuals regardless of race, color, national origin, age, sex, or handicap. Persons who believe they have been denied equal opportunity for participation, may write to the Secretary of Agriculture, Washington, D.C. 20250.

FORWARD

Through Public Law 95-166, monies are available for each state to develop a comprehensive nutrition education program. Plans developed by each state must focus on training school food service personnel in the principles and practices of good food service management. PL 95-166 also calls for state plans to focus on instructing teachers in the sound principles of nutrition education and, most important, on instructing students with regard to the nutritional value of foods and the relationship between food and human health.

Our state plan, which follows, is a milestone in developing a comprehensive nutrition education program for all children in California. It is especially important in that it coordinates classroom instruction with school food service programs. Through the input of many individuals from throughout the state, we have a plan that addresses the needs of children in California and will hopefully provide the base for a continuing statewide nutrition education and training emphasis.

This state plan is a bridge connecting the state nutrition education program with the federal program, thus enabling us to have a comprehensive program that meets the needs of children not only in California but also in all other states of the nation.

PREFACE

The State of California, through the enactment of comprehensive state legislation, has made a major commitment to child nutrition and nutrition education. In 1975, Senate Bill 120 (Chapter 1277) was passed and signed by the Governor, creating the Child Nutrition Facilities Act of 1975. This legislation provides funding for reimbursement for school meals and for nutrition education.

The Child Nutrition Facilities Act provides that nutrition education programs shall be maintained on a project approval basis. Projects may include, but need not be limited to: innovative ways to coordinate the school meal services program with the nutrition education program; development of community resources for purposes of nutrition education; instructional programs for teachers, parents, and food services employees; and training and utilization of paraprofessionals to assist the instructional staff.

In 1977, the United States Congress enacted the National School Lunch Act and Child Nutrition Amendments (Public Law 95-166). The legislation authorizes the Secretary of Agriculture to carry out a program of nutrition information and education.

The purpose of the "Nutrition Education and Training" section of PL95-166 is to encourage effective dissemination of scientifically valid information to children participating, or eligible to participate, in the school lunch program and related child nutrition programs by establishing a system of grants to state educational agencies for the development of comprehensive nutrition information and education programs. Such nutrition education programs shall make full use of the school lunch and child nutrition programs as learning laboratories.

As a result of these legislative milestones, a comprehensive and integrated nutrition education program is now being established in the State of California.

The overall goals of the nutrition education program are to: (1) reach all children, teachers, school administrators, food service personnel, and parents with information about nutrition and the importance of nutrition education; and (2) effect changes in eating patterns which will ultimately result in the improved health and well-being of children.

GENE WHITE, Director
Child Nutrition & Surplus
Property Division

AMANDA DEW MELLINGER, Coordinator
Nutrition Education and Training
Program

Implementation of this State Plan Amendment is subject to change pursuant to enactment of pending State and Federal legislation and availability of funds.

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CHAPTER ONE

NEED FOR NUTRITION EDUCATION AND FOOD SERVICE EDUCATION IN CALIFORNIA

Numerous statistics have validated the need for comprehensive and integrated nutrition education programs to reach children, teachers, school administrators, food service personnel, and the community. The statistics illustrating the need for improving eating habits have provided the basis for two legislative mandates for nutrition education--the Child Nutrition Facilities Act of 1975 (Senate Bill 120) and the National School Lunch Act and Child Nutrition Amendments of 1977 (Public Law 95-166). Both mandates specifically include nutrition education and emphasize the coordination of instructional and food service programs. The purpose of these programs is to effect changes in eating patterns which will ultimately result in the improved health and well-being of children.

The status of nutrition education in California, the needs, a validation of the needs, and planning objectives to meet the needs were outlined in the 1981 State Plan for Management of the Nutrition Education and Training Program.[1] The following statistics offer additional evidence of the need for nutrition education in Caifornia:

- Evaluations returned at ten workshops provided for staff at child care centers and for family day care providers indicated high interest in nutrition education and the need for future workshops with a similar format. One hundred percent of workshop participants responded that the program was helpful. Subject areas suggested for future workshops include cultural foods, infant nutrition, and ideas for planning cost effective menus. Participants indicated enthusiasm about utilizing information received at the workshop including curriculum ideas, recipe ideas, supplementary materials, and suggestions for improving the mealtime environment.

- Dissemination of the state nutrition education curriculum, "Choose Well, Be Well", was conducted in Spring of 1982. Final results showed an overall significant gain in both cognitive and affective test scores for all students, preschool through grade twelve, in classrooms utilizing the curriculum as compared to test scores of a control student population. Plate waste was decreased by 12 per cent over a comparison population.[2]

- Results from nutrition programs developed and implemented at the local level during 1981-82 also showed an overall significant gain in both cognitive and affective test scores for all students. Plate waste was decreased by 13 per cent over a comparison population.[2]

- Relationships between teacher training and student performance warrant further study as a possible means of improving nutrition education in schools.[3] In the curriculum dissemination program and the local agency nutrition programs, trends in improved student performance as a result of teacher training and nutrition knowledge were indicated. In the curriculum dissemination program, teachers indicated a need for increased inservice education before using the "Choose Well, Be Well" curriculum, with emphasis on basic nutrition topics.

- In the curriculum dissemination program and the local nutrition programs, both teachers and administrators indicated that the main obstacle in implementing future nutrition education programs would be the cost of food, materials, and staff in-service.

- Results of a questionnaire to determine the status of past NET funded projects no longer receiving funding showed that 70% of the programs were no longer operating. Only 7% of these programs had ceased operation due to lack of interest, while nearly 85% ceased operation due to lack of resources.

- A review of nutrition education curriculum now available indicates a need for dissemination of curriculum for special target population such as parents, family day care providers, food service personnel, school-age mothers, child care staff, and children in special education programs.

- Evaluations returned at 11 conferences for school and child care food service personnel held during fall 1982 indicated a high interest in attending similar workshops in the future. Nearly 2000 participants attended the conferences. One hundred per cent of the participants indicated they would attend a workshop in 1983. Ninety-six per cent felt the conference was helpful and was applicable to their jobs. Topics for the 1983 workshop include claims preparation, commodities, cost control, meal requirements, nutrition education, and professional growth opportunities.

- An analysis of food service directors' perception of their training needs indicated a strong correlation between perceived needs for training and scores on competency assessment instruments.[4] Competency areas identified include menu planning, fiscal management, introduction to child nutrition programs, staff training, and food procurement. Nutrition was the only competency area where training needs were significantly misperceived. In this study, it was found that those directors who were confident that they had no need for training in nutrition were also those directors who scored most poorly on the assessment instrument measuring nutrition knowledge.

- An analysis of food service assistants' professional training needs indicated that training programs are needed in the following competency areas: nutrition education, quantity food preparation, equipment use and care, personnel management, and merchandising. The data analysis suggested that the food service assistants need to gain a better understanding of their need for further training in order to achieve minimum standards in these competency areas.[5]

- Food service education courses under development through the Nutrition Education and Training Program are meeting the needs of the target groups. The evaluation of the second field test of Menu Design: A Course for Managers of Child Nutrition Programs offered at Fresno City College in June 1982 showed that 94% of the participants rated the course content as good or excellent, 91% rated the course good or excellent in regard to usefulness in career development, and 91% stated that the instructor was well prepared and knowledgeable in her field.

- The Nutrition and Food Service Education Resource Center has been funded by the Nutrition Education and Training Program to provide professionals in nutrition, education, and food service with instructional materials on a loan basis. During FY 1982-83, 550 requests for materials were received, 103 visitors came to the center, and 15 calls per day were received.

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CHAPTER TWO

ROLE AND RESPONSIBILITIES OF THE STATE DEPARTMENT OF EDUCATION PLANS FOR FY 1984 PROGRAM ACTIVITIES

The State Department of Education is charged with the responsibility for implementation of the State Plan for Management of the Nutrition Education and Training Program. In its implementation role during Fiscal Year 1983-84, the Department will meet the identified needs for nutrition education and food service education in California by:

1. Supporting local agency nutrition education grants aimed at student instruction, staff in-service training, materials procurement, and parent/community involvement.
2. Publicizing and disseminating curriculum and materials for special target populations such as day care providers, child care staff, school age mothers and children in special education programs.
3. Disseminating materials supportive of parent/community involvement in nutrition education activities in the community, classroom, and school cafeteria.
4. Publishing and disseminating a competency-based curriculum to instruct food service directors, managers, and assistants in school and child care programs.
5. Increasing and improving the skills level and the professionalism of food service personnel in school districts, child care centers, and in family day care programs.
6. Promoting nutrition education and food service training for staff in licensed or approved child care agencies and family day care homes throughout the state.

The program plan contained in this chapter includes goals, objectives, activities, time lines, and verification of completion. When put into effect, the program plan will contribute to a more coordinated and comprehensive nutrition education program for children.

I. Program Component: Student Instruction

GOAL: To develop and implement a sequential and comprehensive multidisciplinary nutrition education program, preschool and kindergarten through grade twelve, that coordinates instructional approaches and food service activities.

A. Curriculum and Materials Development

OBJECTIVE 1: Finalize curriculum guides containing instructional approaches and food service activities developed to meet the nutrition education minimum proficiency levels for grades seven through twelve.

	ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
a.	Monitor publications process until final guides are printed.	Ongoing to 12-1-83	Copies of printed guides on file.
	OBJECTIVE 2: Develop and finalize materials which enhance the teaching of the preschool through grade twelve curriculum guides.		
a.	Work with Media Services to print developed food picture cards.	Ongoing to 12-1-83	Copies of printed cards on file.
b.	Work with the Bureau of Publications to develop and print color versions of selected student work sheets, Preschool/Kindergarten Curriculum Guide.	Ongoing to 11-1-83	Copies of color supplement on file.
c.	Work with the Bureau of Publications to print the "Resource Manual for Parent/Community Involvement in Nutrition Education Programs".	Ongoing to 11-1-83	Copies of manual on file.
	OBJECTIVE 3: Provide Child Care Facilities with informational pamphlets.		
a.	Disseminate pamphlets to all child care facilities participating in the child nutrition program.	Ongoing	Mailing list on file.
b.	Distribute pamphlets to all child care agencies participating in the "CHOOSE WELL,BE WELL" curriculum implementation at staff development workshops.	10-30-83	List of agencies attending workshops on file.

B. Dissemination

OBJECTIVE 1: Implement a dissemination system for the nutrition education instructional materials for preschool through grade twelve students to school personnel responsible for implementing instructional programs in school districts and private nonprofit educational agencies.

a.	Distribute brochure announcing the availability of the nutrition education instructional program for preschool through grade twelve.	Ongoing	Copies of promotional materia on file.
b.	Distribute brochure announcing funding for nutrition education instructional program for preschool through grade twelve.	3-1-84	Copies of brochure on file. Mailing list on file.

	ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
c.	Fund local educational agencies to implement the preschool through grade twelve nutrition education instructional program.	5-30-84	Letters of Agreement on file.
d.	Establish a county office of education network to assist in the promotion and dissemination of the preschool through grade twelve nutrition education program.	5-30-84	List of county liaison person on file.
	(1) Place one set of instructional materials in each county office of education.		

C. Staff Development

OBJECTIVE 1: Develop and implement a staff development program for teachers, administrators, food service personnel, and school health personnel, on the philosophy of nutrition education, instructional approaches, food service activities, and methods of incorporating nutrition education into the total school curriculum.

	ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
a.	Develop a leadership package for conducting staff development for junior high and high school staff implementing "CHOOSE WELL, BE WELL" instructional program.	11-30-83	Leadership package on file.
b.	Work with Media Services to develop a 16 mm promotional film to aid in the "CHOOSE WELL,BE WELL" staff development program for junior high and high school staff.	12-30-83	Film in use.
c.	Conduct preschool through grade six staff development program for mini-grant agencies.	10-30-83	Locations and registration forms on file. Copy of workshop evaluation on file.
d.	Develop a system for responding to statewide requests for staff development.	10-30-83	
e.	Conduct junior high and high school staff development for mini-grant agencies.	2-30-84	Locations and registration forms on file. Copy of workshop evaluation on file.

	ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
D.	Special Projects		
	OBJECTIVE 1: Guide and monitor local educational agencies funded to disseminate nutrition education programs to special target populations: school-age mothers, family day care providers, special education students, and food service personnel.		
a.	Conduct planning meeting for project personnel.	10-1-83	Agenda on file.
b.	Attend first regional meeting for each project.	1-15-84	Evaluation reports on file.
c.	Provide technical assistance as needed.	Ongoing	Documentation on file.
d.	Monitor local project reports due February 1 and June 30.	Ongoing	Copy of reports on file.
	OBJECTIVE 2: Address the nutrition education needs of further special target populations by providing grants to local agencies to develop innovative and creative nutrition education programs which will, in future years, be available for dissemination.		
a.	Conduct meetings to determine areas of greatest nutrition education needs.	10-30-83	Minutes on file.
b.	Develop guidelines for applying for funding.	12-15-83	Guidelines on file.
c.	Publicize the availability of funds.	1-15-84	Announcement on file.
d.	Receive and evaluate proposals.	3-1-84	Log on file.
e.	Prepare recommended list for Child Nutrition Advisory Council review and State Board of Education approval.	5-1-84	List on file.
f.	Provide guidance, technical ongoing assistance and monitoring to grant agencies.	Ongoing	

II. Program Component: Food Service Education

GOAL: To develop and implement a statewide professional growth program for school and child care food service personnel including a competency-based curriculum offered through school districts, colleges, and universities.

A. Curriculum and Materials Development

OBJECTIVE 1: Duplicate the final edition of the curriculum for three courses, one each for the food service assistant and manager levels and two courses for the food service director level.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
a. Duplicate(print) Basic Skills: Basic Foods, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the food service assistant level.	4-30-84	Curriculum on file.
b. Duplicate (print) Menu Design for Child Nutrition Programs, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the manager level.	4-30-84	Curriculum on file.
c. Duplicate(print) Introduction to Child Nutrition Programs, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the director level.	4-30-84	Curriculum on file.

OBJECTIVE 2: Revise and duplicate the site validation edition of the curriculum in three courses, one for each level of food service personnel.

a. Finalize, validate, edit and mimeograph Introduction to Child Nutrition Programs, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the food service manager level.	8-30-84	Curriculum on file.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
b. Finalize, validate, edit and mimeograph Food Procurement for Child Nutrition Programs, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the manager level.	8-30-84	Curriculum on file.
c. Finalize, validate, edit and mimeograph Menu Design for Child Nutrition Programs, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the director level.	8-30-84	Curriculum on file.
d. Finalize, validate, edit, and mimeograph Staff Training for Child Nutrition Programs, a curriculum series which includes three publications: an administrator/instructor guide, a course of study, and a participant resource book for the director level.	8-30-84	Curriculum on file.
e. Finalize, validate, edit, and mimeograph Orientation Course of Study and Resource Book for Level I and Level II Trainers.	8-30-84	Curriculum on file.

OBJECTIVE 3: Develop and disseminate informational printed materials on key issues in food service education and training.

a. Revise and publish the Proceedings from the San Diego State Level I and Level II Training Session.	6-30-84	Publication on file.
b. Develop program for the annual conference series "Current Issues in Child Nutrition Programs."	10-1-83	Publication on file.
c. Revise a fact sheet on the Food Service Education Component.	10-1-83	Publication on file.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
d. Search out/develop materials for teacher kits for distribution to training cadre for each course; assemble and distribute teacher kits at training sessions.	Ongoing	Three sample kits on file.
e. Distribute copies of completed food service curriculum to postsecondary institutions, to state food service directors/NETP coordinators, and to the USDA Food and Nutrition library.	2-1-84	Records of distribution on file.
f. Finalize,validate,edit, and duplicate _Essential Competencies for Food Service Personnel_.	12-31-83	Publication on file.
g. Work with state staff and Child Nutrition Advisory Council in establishing professional standards for food service personnel.	9-30-84	Minutes on file.

OBJECTIVE 4: Develop and disseminate visual materials on key issues in food service education and training.

a. Work with Media Services to develop a filmstrip-tape on work improvement procedures for food service personnel.	9-30-84	Filmstrip-tape on file.

B. Dissemination

OBJECTIVE 1: Develop and implement a program of training for school and child care management level personnel.

a. Plan and implement in cooperation with other Office of Child Nutrition Service units, the Local Assistance Bureau, and the Audit Bureau, the second annual workshop series "Current Issues in Child Nutrition Programs" at ten locations in the state.	11-15-84	Program and evaluation results on file.

OBJECTIVE 2: Plan and implement a system for the field test and site validation of food service education courses.

a. Site validate _Basic Skills: Basic Foods_ course for the food service assistant level at 30 community colleges/school districts.	6-30-84	Course implementation plans on file.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
b. Site validate Menu Design course for the food service manager level at 10 community colleges.	6-30-84	Course implementation plans on file.
c. Site validate Introduction to Child Nutrition Programs for food service directors at one state university.	6-30-84	Course implementation plans on file.
d. Site validate Orientation to Child Nutrition Programs for Level I and Level II Trainers at one state university.	6-30-84	Course announcements on file.

OBJECTIVE 3: Plan and implement a system for the dissemination of food service education materials.

a. Disseminate the following curricula through the State Department of Education Cashier's Office: - Basic Skills: Basic Foods--food service assistant level - Menu Design- manager level - Introduction to Child Nutrition Programs - director level	9-30-84	Distribution records on file.

C. Staff Development

OBJECTIVE 1: Develop and implement a training program for instructors of food service education courses.

a. Conduct three(six hour) orientation sessions for instructors responsible for disseminating the following courses: - Basic Skills: Basic Foods--food service assistant level - Menu Design--manager level - Introduction to Child Nutrition Programs--director level	8-31-84	Program & evaluation on file.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
b. Conduct three(six hour) orientation sessions for instructors responsible for site validation of each of the following courses: -Menu Design- director level -Introduction to Child Nutrition Programs--manager level Staff Training--director level -Food Procurement -manager level	8-31-84	Program and evaluation on file.
c. Conduct one thirty-hour session for new Level II trainers.	5-31-84	Program and evaluation on file.

D. Special Projects

OBJECTIVE 1: Guide and monitor local educational agencies funded for FY 1983-84 to disseminate food service education minigrant programs to school and child care personnel.

a. Conduct orientation meetings for project personnel.	10-1-83	Agenda and evaluation on file.
b. Provide telephone and onsite technical assistance as needed.	Ongoing	Documentation on file.
c. Conduct onsite visits.	Ongoing	Copy of reports on file.
d. Monitor minigrant project reports due February 1 and June 30.	Ongoing	Copy of reports on file.

OBJECTIVE 2: Allocate funds for FY 1984-85 to local agencies to disseminate food service education minigrant programs to school and child care personnel.

a. Develop and distribute guidelines for food service education minigrant program.	1-1-84	On file.
b. Develop and distribute minigrant announcement brochure; receive applications.	1-15-84	On file.
c. Select and notify funded projects.	3-1-84	Letter on file.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
d. Receive and review implementation plans and budgets.	4-1-84	On file.
OBJECTIVE 3: Address the food service education needs of further special target populations by providing grants to local agencies to develop innovative and creative food service education programs which in future years will be available for dissemination.		
a. Determine in cooperation with other NETP staff areas of greatest food service education need for project implementation.	10-30-83	Minutes on file.
b. Assist in preparing guidelines for funding application.	12-15-83	Guidelines on file.
c. Evaluate food service education proposals.	3-1-84	Log on file.
d. Prepare recommended list for funding.	5-1-84	List on file.
e. Provide guidance, technical assistance, and monitoring to grant agencies.	Ongoing	Record of visits and/or contacts on file.

III. Program Component: Public Awareness

GOAL: To increase the awareness of, support for, and involvement in the NET Program; to ultimately promote the importance of nutrition in overall health.

A. Resource Center

OBJECTIVE 1. Maintain and promote the Nutrition and Food Service Education Resource Center for use by nutrition, food service, and education professionals.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
a. Publicize Resource Center	Ongoing	Mailing lists on file.
b. Collect and review new materials.	Ongoing	Documentation on file.
c. Update and expand current resource list.	10-31-83	Resource list on file.
d. Investigate sources for future funding of resource center.	Ongoing	Documentation on file.

B. Media Products

OBJECTIVE 1: Develop and distribute public service announcements to reinforce concepts used in the NET Program.

b. Work with Media Services to develop public service announcements.	1-30-84	PSAs on file.
c. Work with Media Services to distribute PSAs throughout California.	3-31-84	Records of distribution on file.

C. Publicity

OBJECTIVE 1: Continue to conduct an intensive public information campaign to increase the awareness of NET.

a. Publish articles in magazines, appear on talk shows, issue press releases, speak at conventions, participate in statewide exhibits, develop mailings, media packets, etc.	Ongoing	Articles, releases, and letters on file.

ACTIVITIES	TIME LINE	VERIFICATION/EVALUATION
b. Update, print and distribute NET Program informational brochure.	12-31-83	Brochure on file.

D. Interaction with Governmental Agencies and Individuals

OBJECTIVE 1: Continue to gather support at the state and federal levels for the NET Program.

a. Contact key individuals to increase their awareness of the successes of NET and relay how they can help to support the program.	Ongoing	Record of contact on file.

State Department of Education
Office of Child Nutrition Services

Nutrition Education and Training Program
June 15, 1983

1983 - 84 BUDGET
NUTRITION EDUCATION AND TRAINING

		Federal Share	State Cash Match	State In Kind Contribution
I.	ADMINISTRATION			
	A. Audits	$ -	$ 10,527	$ -
	B. Communications	10,555	-	-
	C. Facility Operations	8,476	3,021	2,310
	D. Indirect	61,052	15,434	11,799
	E. Personal Services	-	51,101	-
		$ 80,083	80,083	$ 14,109
	F. Salaries & Wages	$177,829	$ -	$ 39,072
	G. Salary Savings	-34,480	-	-
	H. Benefits	39,994	14,256	10,901
	I. Master County Contracts	3,944		
	J. Travel	19,923		
	K. Postage	6,000		
	L. Duplicating	9,000		
	M. Word Processing	11,000		
	N. General Expenses	15,711		
		$248,921	$ 14,256	$ 49,973
II.	STUDENT INSTRUCTION	$ 30,000	$281,136	$ -
	A. Curriculum & Materials Development			
	B. Curriculum & Materials Dissemination			
	C. Staff Development			
	D. Special Projects			
III.	FOOD SERVICE EDUCATION & TRAINING	$ 30,000	$298,928	$ -
	A. Curriculum & Materials Development			
	B. Curriculum & Materials Dissemination			
	C. Staff Development			
	D. Special Projects			
IV.	OUTREACH - PUBLIC AWARENESS	$ 20,767	$ -	$ -
	A. Resource Center			
	B. Media Products			
	C. Publicity			
	D. Interaction with Governmental Agencies and Individuals			
TOTALS		$409,771	$674,403	$ 64,082

OFFICE OF THE MAYOR
SAN FRANCISCO

DIANNE FEINSTEIN

Task Force on Food and Hunger

PRELIMINARY SUMMARY OF MAYOR'S TASK FORCE ON FOOD AND HUNGER

During the past year numerous commissions, elected officials, and advocacy organizations have examined the question of hunger in America. From the President's Task Force and the U. S. Conference of Mayors to Senator Kennedy's five-city investigation and the Citizen's Commission on Hunger in New England, each has concluded that the ability of people to take care of their own food needs is eroding, and more and more families are hungry in America. A survey of 55 cities identified food as the emergency service most in need.

Because of the clear, undeniable and authoritative evidence of a food crisis both nationally and locally, Mayor Diane Feinstein established a local Task Force on Food and Hunger charged with a three-fold task: (1) measuring the status of hunger in San Francisco; (2) identifying gaps/needs in food services both ongoing and emergency; and (3) proposing recommendations to alleviate the crisis. The Task Force met for the first time in March, 1984, and quickly realized that the harsh problems facing many in our midst demanded our attention.

The Task Force has prepared this preliminary summary to present to today's hearing of the House Select Committee on Hunger. Because of the shortness of time in the scheduling of the hearing, and the activities of the Democratic National Convention here in San Francisco, the Task Force has not yet discussed our recommendations with the Mayor. We intend to meet with the Mayor and will release a full report in the fall.

The combined impact of budget reductions in all federal aid programs, from food to shelter to income assistance, has reduced the ability of low-income people to meet their most basic survival needs. California has lost a total of $9.3 billion in federal aid since 1981, an amount equal to $383 per person in the state. In San Francisco, where fixed costs are so high, food is often the most optional item. Dwindling federal food assistance, chronic unemployment and underemployment, and a high cost of living has translated into a dramatic increase in the need for local emergency food assistance. Many agencies are delivering service to the maximum capacity for their resources - both human (time and energy) and material (buildings and equipment). Existing emergency meal programs are underfunded and therefore unable to adequately meet the growing demand. The federal funding for emergency food (FEMA) made it possible for these programs to temporarily address the food needs of those who were cut out of established programs. But the abrupt ending of this federal program left agencies without resources to meet the increased demand. The temporary expansion of emergency food programs did not satisfy the need - rather it has only served to expose the enormity of the problem.

Evidence uncovered by the Task Force is overwhelming and startling. Preliminary observations reveal that:

- requests for emergency food assistance in the City and County of San Francisco have doubled over the last year.
  - * St. Vincent de Paul Society reported that in 1980 they served 4,000 meals per month, and currently they serve 25,000 monthly.
  - * The Glide Community Food Program serves three meals each day of the year to 3,000 people, yet turns hungry people away daily.
  - * Self-Help for the Elderly in Chinatown serves hot meals to 4,000 seniors each week. Frail seniors must wait in long lines in order to reserve their next day's meal, and many have to be turned away.
  - * In 1983, the S. F. Food Bank distributed 20,000 pounds of food each month. In 1984, it is distributing over 90,000 pounds per month.
  - * The Summer Food Service Program distributed 250,000 free lunches to needy children in 1983 - 50,000 more than the year before.

- the nature of those relying on public food distribution has changed, many of them are now from families suffering the effects of long-term unemployment, high rents, and reduction in federal aid.

  * 65% of the food boxes given away through the Emergency Food Box and other neighborhood pantries go to women with children.

  * St. Anthony's Dining Room reports that more and more children are coming to their meal program during school hours.

  * Glide Community Food Program was forced to cut back its services to single men and women in order to serve the growing numbers of households with children.

  * Childcare centers throughout the city report that children come to their centers hungrier, yet their available food has been severely cut back.

- despite the extraordinary efforts of both public and private groups to meet the growing demand for food, it is clear that the need is not being met.

  * the S. F. Supplemental Food Program for Women, Infants, and Children (WIC) is only able to serve 23% of those potentially eligible for its benefits.

  * emergency food providers are forced to turn people away because they either do not have enough food to distribute, or they have inadequate facilities to store and prepare food.

  * most of the over 10,000 seniors of the City's Tenderloin area live in single room occupancy (SRO) hotels with no means of storing or preparing food and use illegal hot plates with the ever present fire danger.

  * homebound, elderly and disabled remain on waiting lists to receive home delivered meals.

  * the release of the chronically mentally disabled from institutions without adequate community support services adds a permanent demand to the already strained resources of both publicly supported and voluntary feeding programs.

  * the immigrant, refugee, and undocumented populations remain outside most food service programs because of language difficulties, cultural prohibitions, confusion and fear of deportation.

  * U.S.D.A. commodities are sporadic, do not meet the nutritional needs of most adults, and are often detrimental to the health of special populations.

As service providers in this land of abundance, we face the unbelievable paradox of increasing numbers of hungry people waiting in food lines while 20% of all food produced in our country is wasted before it ever reaches the consumer. We need to examine how the food industry contributes to the problem of hunger. More importantly, we must look at how our governmental policies can better work to protect the needs of the consumer as well as those of the industry. The four-mile long caves that hold the USDA surplus cheese and butter at considerable expense are one example of the subsidy programs and policies the federal government promotes to artificially support the food industry. Paying farmers not to farm their land and then giving them surpluses of the same crops they would have produced to sell for profit in the market place (P.I.K. Program), is another. Allowing orange growers to plow under bumper harvests of smaller than standard sized fruit, or allowing food manufacturers to hold back coffee and sugar in order to keep prices high are other examples of how our food policies are imbalanced to protect the right to profits over the right to eat.

We must coordinate our technical capacity to produce food with an ecologically sensitive plan to utilize our land productively over time. We must develop policies which promote the production of food to meet the nutritional needs of all our citizens. As our technical ability increases and more goods are produced with less human labor, our priorities must be shifted. We must utilize the energy and talents of our people to ensure their right to survival. A working economy with adequate support services for those unable to work must be developed, or the numbers of jobless, homeless, and hungry will continue to grow.

Hunger is due to poverty and the inequitable distribution of resources, not to inadequate supplies of food in this land. Equal access to employment opportunities and fair wages is the only way to alleviate hunger in our communities. Adequate income will allow everyone to meet their fixed costs of rent, utilities, and health care with enough left over to purchase nutritious food. Until such opportunities exist, the need for government and privately sponsored food programs remains paramount.

The Task Force received information from a broad spectrum of federal, state, local, and privately funded food programs (over 100 programs), and would like to offer the following recommendations:

FOR SENIORS AND ADULT DISABLED:

1. upgrade and/or expand existing facilities, equipment, staffing, operating costs and number of meals for congregate and home delivered nutrition programs.

2. expand existing/new home delivered meal programs and extend programs to the adult disabled under 60 years of age.

3. provide for greater ethnic diversity and special dietary needs of participarts.

4. increase HUD funding to assure that new and rehabilitated senior residences have congregate meal space with allowances for the development of central kitchens.

5. extend food services to outlying neighborhoods.

6. subsidize congregate meals at Housing Authority and other residences for low-income residents.

7. enact legislation to establish commodities supplemental food program in S. F. to provide nutritious monthly food packs to senior citizens.

8. provide hotels for the chronically mentally ill staffed by case managers with congregate meal program on site.

FOR FOOD STAMPS:

1. change basis upon which food stamp allocation is made - the Thrifty Food Plan is neither economically nor nutritionally adequate.

2. mandate local emergency food stamp issuance within 48 hours.

3. appoint a committee to look at local Food Stamp program and the effectiveness of current pilot programs; also look at state options and federal regulations as they relate to local implementation problems. Monthly reporting and retrospective budgeting need to be eliminated.

4. set up an advocate program in D.S.S./S.F. so those that need assistance can have someone walk them through the system.

5. investigate the possibility of using food stamps to buy prepared foods - i.e. restaurants.

FOR CHILDCARE PROGRAMS:

1. restore full funding for three meals and two snacks, and encourage flexability for special dietary needs - ethnic, health-related, etc.

2. create more subsidized licensed childcare centers, and encourage the development and support of family daycare homes.

3. restore the tiering system for U.S.D.A. reimbursement of childcare programs.

4. restore money for equipment assistance to meet meal production needs.

5. simplify program paperwork requirements.

FOR SUMMER FOOD PROGRAMS:

1. add one meal type to provide adequate meals for children in the summer.
2. allow reliable non-profit agencies to run the program.

FOR W.I.C. PROGRAMS:

1. double the funding for the W.I.C. program, in order to reach more of the eligible population.

FOR NUTRITION EDUCATION AND ADVOCACY:

1. establish an office of nutrition in the Dept. of Public Health to: (a) provide nutrition education and technical assistance to public and private non-profit agencies; (b) be a clearinghouse and referral service for nutrition education materials, and a facilitator between agencies with similar constituencies, and (c) operate an ongoing nutritional assessment and monitoring system locally to tie into state and federal efforts.
2. fund nutrition education component in all food programs, for both providers and recipients.
3. present ongoing workshops in nutrition education to train non-professionals in food programs.
4. support state legislation to make nutrition education a requirement for MD's and teachers.
5. work with the Board of Education on promoting more nutrition and consumer eduation in Kindergarten through High School, i.e. incorporate into science, math, reading, and other subjects. Skills development in food planning and preparation should be taught to ALL children.
6. support funding of more trained personnel (registered dietitians) in public agencies, and allow them program support money for supplies and materials to be used in demonstrations.
7. base food distribution programs on nutritional needs rather than available surplus items such as cheese and butter.
8. improve the nutritional quality of USDA surplus commodites (i.e. levels of sodium, fat, sugar content).
9. establish an ongoing nutritional assessment system on a national basis that takes into account the multi-ethnic composition of our population.

10. provide third-party payment for nutrition services by registered dieticians.

FOR EMERGENCY FOOD PROGRAMS:

1. reactivate FEMA program with increases to meet growing needs for emergency food supplies, and assure service for full calendar year.
2. develop ongoing funding for emergency food resources.
3. restore administrative funds from 2.8% to 5% from State Dept. of Ed. for USDA surplus commodity distribution. Increase the allotment and nutritional quality of commodities to S.F. so that more centers can be set up with EOC.
4. develop jobs programs to facilitate the distribution of salvage foods.
5. set up coordinated canned food collection program to assist emergency food programs.
6. develop coordinated bulk-buying of food for emergency food programs.
7. provide drop-in centers like St. Anthony's during the night hours, with hot snack and socialization available.
8. provide more meal/food programs on weekends/holidays when other services are not available.
9. develop a mobile canteen system that can serve a wide geographical area.
10. encourage cooperation and information sharing among both public and private food programs - especially linking food box/pantries and emergency meals in the same geographic area.

OTHER FOOD ACCESS ARENAS:

1. improve quality, availability and affordability of dental services for low-income people.
2. promote prototypes for Single Room Occupant (SRO) hotels in food storage, community kitchens, refrigeration, and safe legal hotplates.
3. promote community gardening and gleaning programs in San Francisco.
4. increase transportation options for all ages to get to where the food is.
5. develop a transportation system so that agencies can get to food sources.
6. improve delivery systems to get groceries to people who can't get out themselves.

7. increase access to affordable food - vending machines with healthy choices, farmers markets, co-op stores, food-buying clubs, mini-markets, etc.

Future of the Task Force:

It is important to continue the Task Force on Food and Hunger to serve as a clearinghouse and communications link, expand membership, and enlist the help of others as needed, i.e. meeting with the funding community, technical advisors, etc.

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San Francisco, California 94112

Margaret Furnish, Assistant Director
Food Stamps Program
P. O. Box 7988
San Francisco, California 94102
557-5849

Nylda Gemple, RD
Laura Brainin-Rodriquez, Nutritionist
San Francisco Women, Infant and Children Program
Health Center #1
3850 - 17th Street
San Francisco, California 94115
621-3921

Steve Graham, Director
Services for Seniors
1500 Laguna Street
San Francisco, California 94115
922-5438

Zoraina Harris, Program Manager
Mayor's Feinstein's Office
City Hall, Room 205
San Francisco, California 94102
558-5974

Jan Hartsough, Program Associate
Producer Consumer Project
American Friends Service Committee
2160 Lake Street
San Francisco, California 94121
752-7766

Rev. Frederick Hubbard, Director
Western Addition Senior Center
1390 Turk Street
San Francisco, California 94115
921-8705

David Ishida, Nutrition Project Director
Kimochi, Inc.
1581 Webster Street #10
San Francisco, California 94115
931-2294

Dorrwin B. Jones, Director
Meals on Wheels
1290 Sutter Street
San Francisco, California 94109

Steve Van Landingham, Program Director
San Francisco Emergency Food Box
208 Dolores Street
San Francisco, California 94103
621-7575

Bonnie MacGregor, Director
San Francisco Food Bank
333 Illinois Street
San Francisco, California 94107
957-1076

Marion Standish, Attorney at Law
California Rural Legal Assistance Foundation
2111 Mission Street, Suite 401
San Francisco, California 94110
864-3414

Patti Whitney-Wise
California Rural Legal Assistance Foundation
2111 Mission Street, Suite 401
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Stephen D. Whitney-Wise
Jay Borell
St. Anthony's Foundation
121 Golden Gate Avenue
San Francisco, California 94102
552-3838

Claudius "Dusty" Williams
Director, Food Program
Glide Memorial Church
330 Ellis Street
San Francisco, California 94102
441-6501

MAYOR DIANNE FEINSTEIN'S TASK FORCE ON FOOD AND HUNGER GOALS

1. Assess needs
2. Publish a Directory of Food Services
3. Define gaps in services
4. List of recommendations
5. Develop a strategy of implementing the recommendations

GENERAL MANAGER'S COMMENTS

This year, unlike the past five, has been relatively serene. Instead of continuing resolutions and the attendant anxiety they cause, we have a Federal budget for the first time in five years. The State budget will be adopted in a timely fashion. Several critical issues will be decided in the coming months. Immigration reform and America's refugee resettlement policies will be addressed in this Congressional session. California will vote in November on convening a Constitutional Convention mandating a balanced Federal budget as well as on initiative measures which could significantly reduce AFDC benefits in California and halve the income available to these poorest of families. The data put forth under the umbrella of "feminization of poverty" is of serious concern and unless policy directions are changed we will see an all women and children poverty population by the end of this century.

Significant changes will occur within the Department this fiscal year including increased automation and systems enhancement, increased short- and long-range planning, year-round budget planning, expanded adult services and greater emphasis on our volunteer program.

This briefing book continues to be refined and your comments on its contents would be most welcome.

I am deeply proud of the Department's staff and their continued dedication and commitment, and am appreciative of the Social Service Commission for their continued support and confidence.

Edwin S. Sarsfield

EDWIN S. SARSFIELD
General Manager
Department of Social Services

DEPARTMENT OF SOCIAL SERVICES

OFFICE LOCATIONS

Mailing Address for all posted correspondence:

P. O. Box 7988
San Francisco, CA 94120

Office locations for inter-office correspondence:

170 Otis Street

General Manager, Assistant General Manager
Accounting, Administrative Services, AFDC
Adult Services, Family & Children's Services
Foster Care

150 Otis Street

Medi-Cal Program, Fraud Investigation
Claims and Collections, Overpayments
Homeless Program

1680 Mission Street

General Assistance Program
Central Index/Closed Files

1360 Mission Street

Food Stamps Program
Community Services/Volunteer Services
Commission on the Aging

Andrew Jackson School, 2049 Grove Street

Shelter School for dependent children
Children's Emergency Services

DEPARTMENT OF SOCIAL SERVICES

RESOURCE PERSONS

Edwin S. Sarsfield, General Manager	557-6541
Judy Schutzman, Executive Assistant	557-6432
Vicky Sison, Secretary	557-6541
Masaya Kakebe, Assistant General Manager	557-6541
Secretary	557-6541
Thomas J. Flaherty, Supervising Fiscal Officer	557-6536
Rose Lou Randolph, Director of Administrative Services	557-6424
S. Rod Umino, Assistant Director - Civil Rights/Aff.Action	557-6574
Assistant Director - AFDC	557-6321
Bert Webb, Assistant	557-6278
Margaret Furnish, Assistant Director - Food Stamps	557-5849
Larry Grube, Assistant	557-5854
Ronald Gallegos, Assistant Director - Medi-Cal	557-6150
Ralph Mistler, Assistant	557-6152
Lillian Johnson, Assistant Director - Fam. & Childrens Svcs.	557-6333
Clyde Williams, Assistant	557-6335
June Keller, Assistant Director - Adult Services	557-6438
Ted Osborn, Assistant	557-5237
Robert Becker, Assistant Director - General Assistance	557-5899
Anthony Nicco, Assistant	557-5806
Mary Beem, Secretary to Social Services Commission	557-6431

DEPARTMENT OF SOCIAL SERVICES

RESOURCE PERSONS BY SUBJECT

AFDC	John Borelli	557-6302
Adult Services	June Keller	557-6438
Family & Children's Svcs	Lillian Johnson	557-6333
Food Stamps	Margaret Furnish	557-5849
General Assistance	Robert Becker	557-5899
Medi-Cal	Ronald Gallegos	557-6150
Fiscal/Accounting	Thomas Flaherty	557-6536
Civil Rights Complaints	Rod Umino	557-6574
Personnel/Payroll	James Horan	557-5570
Statistics	Paul Rosenberg	557-5544
Chore Service Payments	Aine O'Brennan	557-5822
Contracts	Robert Cowan	557-5579
Community Services	Eugene Louis	557-5686
Foster Home Licensing	Frances Terziev	557-5147
Adoptions	Brian Quinn	557-5109
Adult Protective Services	Jerome Fishman	557-5228
Childrens Protective Svcs	David Hanlon	387-9010
Volunteer Services Program	Eugene Louis	557-5517
Information		
General		864-0948
General Assistance		864-0948
AFDC		557-5723
Food Stamps		557-5718
Medi-Cal		557-6072

Complaints

Adult Services/Homemaker Chore Services	557-6438
AFDC Eligibility - Appeals	557-5783
Affirmative Action, Civil Rights	557-6574
Family & Children's Services	557-6333
Food Stamps	557-5847
Fraud/Suspected Fraud	557-5807
General Assistance	557-5899
Medi-Cal	557-6156
General	864-0948
Ombudsman	557-6322

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Program Description

The AFDC Program provides financial assistance, Medi-Cal benefits and Food Stamps to families who are in need as a result of deprivation of parental support or care. Current recipients number 13,000 families and represent 24,000 children receiving benefits each month. The majority of beneficiaries are children and the majority of families are single women with an average of two children. The AFDC Program is mandated by both Federal and State law.

Funding

Annual benefits expenditures are $75 million. Federal, State and County participation in funding is at a ration of 50%:44.8%:5.2% with a county share of $3.9 million.

Staffing

AFDC is staffed by 129 line workers and supervisory personnel with 33 support staff which include clerical and administration. Annual salary costs are $3.6 million.

Trends

The AFDC Program has experienced a shift in the types of families receiving assistance. Since fiscal year 1980/81, the number of families on aid as a result of unemployment has increased by 82.5% while the number of families receiving aid because of the death, absence or incapacity of either parent has declined by 12.6%. San Francisco's AFDC population continues to decline given the rising cost of housing in our county. Further reductions are forecast. There is considerable concern that the issues set forth in the feminization of poverty data suggest that we need policy changes to avoid all of our nation's poor being women and children by the end of this century - just 16 years away.

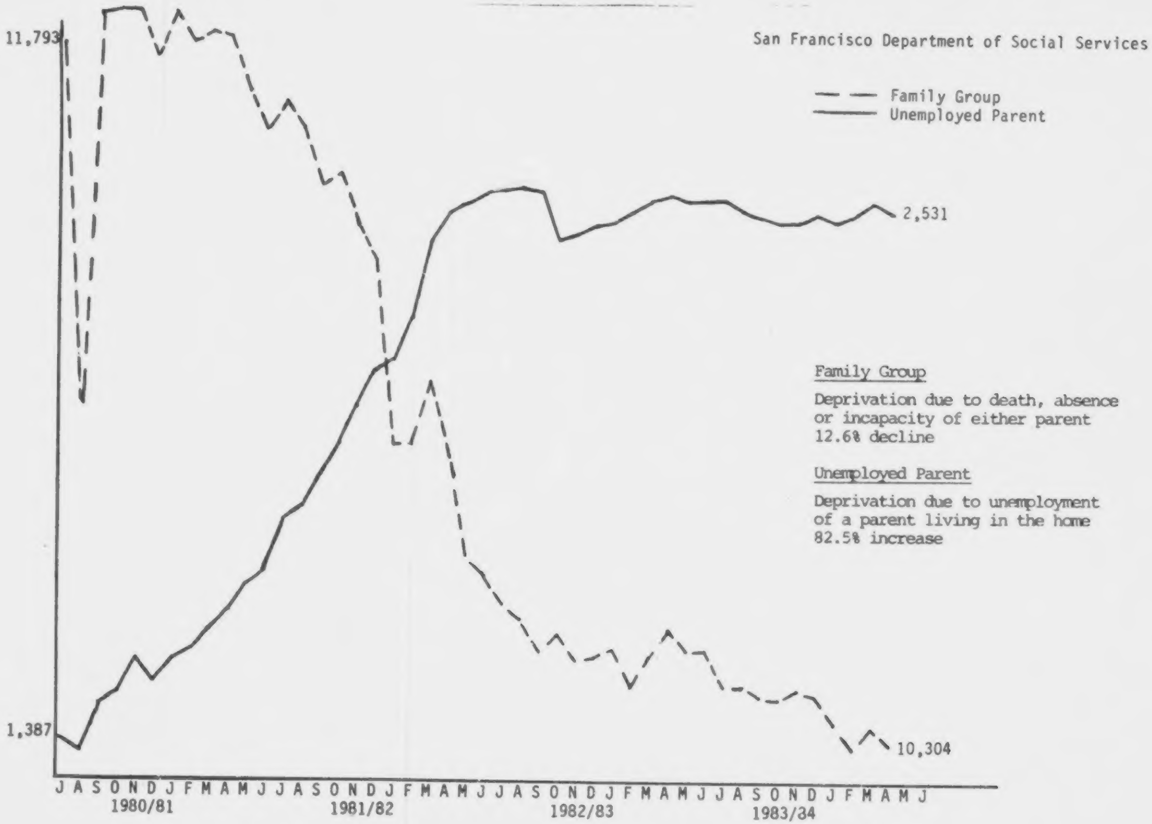
SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES

AID TO FAMILIES WITH DEPENDENT CHILDREN
CASELOADS AND EXPENDITURES/FISCAL YEARS 1980/81 to 1983/84

	1980/81			1981/82			1982/83			1983/84		
	Cases* Handled	Cases** Paid Aid	Expenditures	Cases Handled	Cases Paid Aid	Expenditures	Cases Handled	Cases Paid Aid	Expenditures	Cases Handled	Cases Paid Aid	Expenditures
Jul	14,254	13,180	$ 4,506,412	13,906	13,534	$ 5,824,965	13,454	13,166	$ 5,811,456	13,213	12,966	$ 5,715,671
Aug	14,358	12,383	6,569,443	13,820	13,506	5,835,123	13,442	13,139	5,649,126	13,180	12,941	5,992,408
Sep	14,491	13,340	5,443,256	13,785	13,453	5,824,828	13,339	13,061	5,822,587	13,123	12,905	5,725,477
Oct	14,640	13,376	5,323,627	13,870	13,550	5,946,169	13,239	12,996	5,494,534	13,128	12,891	5,782,028
Nov	14,651	13,382	5,456,201	13,785	13,515	5,918,013	13,205	12,944	5,692,929	13,141	12,907	5,942,156
Dec	14,797	13,288	5,405,127	13,864	13,515	5,944,264	13,233	12,975	5,724,384	13,125	12,910	5,952,518
Jan	13,789	13,441	5,323,011	13,524	13,145	5,850,396	13,273	12,992	5,704,533	13,054	12,835	5,837,650
Feb	13,672	13,384	5,289,565	13,612	13,232	5,885,876	13,216	12,950	5,716,507	13,007	12,800	5,828,735
Mar	13,809	13,447	5,313,119	13,804	13,533	6,111,495	13,312	13,037	5,835,089	13,186	12,890	5,990,413
Apr	13,795	13,481	5,287,584	13,745	13,436	6,027,821	13,338	13,098	5,652,527	13,097	12,835	5,734,455
May	13,707	13,412	5,215,275	13,570	13,238	5,847,335	13,329	13,042	5,739,752	13,020	12,751	5,814,901
Jun	13,733	13,370	5,214,900	13,514	13,214	5,734,726	13,326	13,040	5,599,977		Not Available	
Total	169,696	159,484	$64,347,520	164,799	160,871	$70,751,011	159,706	156,440	$68,453,401	144,274	141,631	$64,316,412
Ave/Mon	14,141	13,290	$ 5,362,293	13,733	13,406	$ 5,895,918	13,309	13,037	$ 5,704,450	13,116	12,875	$ 5,846,947

*Cases Handled - Total of cases open during month
**Cases Paid Aid - Total of cases which received a cash payment during month

ource: CA237 FG/U AFDC Cash Grant Caseload Movement and Expenditure Report



Family Group

Deprivation due to death, absence or incapacity of either parent
12.6% decline

Unemployed Parent

Deprivation due to unemployment of a parent living in the home
82.5% increase

AID TO FAMILIES WITH DEPENDENT CHILDREN
COMPARISON OF AID TYPES 1980/81 to 1983/84

WORK INCENTIVE (WIN)

Program Description

The Work Incentive Program is a cooperative program between the Department and the California Employment Development Department (EDD) which provides AFDC recipients incentives, opportunities and services to obtain training and employment. All AFDC applicants and recipients are required to register for WIN as a condition of eligibility unless they are exempt. The Department provides social workers, outstationed at EDD centers, who are responsible for appraisal, certification and supportive services. Arrangements for, and approval for payment of, WIN day care services is also provided. The program is mandated by Federal law.

Funding

WIN Day Care assistance is funded at $40,000, 90% of which is Federal and 10% County dollars. Staff costs are 90% Federal and 10% State.

Staffing

The program is staffed by four senior social workers and three support personnel at an annual cost of $198,000.

Trends

Continuation of the WIN Program has been debated at the Federal level for the past three years and funding remains uncertain. Given concern over the control of the AFDC error rate and potential Federal and State fiscal sanctions, a co-location of the EDD function at AFDC intake is being considered.

REFUGEE RESETTLEMENT PROGRAM (RRP)

Program Description

The Refugee Resettlement Program (RRP) provides financial assistance, Medi-Cal benefits and Food Stamps to persons who have been granted refugee or entrant status by the Federal government. The current county refugee population includes Indochinese, Eastern European (Rumanian, Russian), Middle Eastern (Afghanis), East African (Somalis), Cubans, and Haitians. The Refugee Resettlement Program is mandated by the Federal Refugee Act of 1980. Cases aided number 600.

Funding

Benefit expenditures are $5 million and are 100% reimbursed by the Federal government for the first 18 months of eligibility. An addtional 18 months of Federal funding is available for those persons and families who are eligible to General Assistance and AFDC.

Staffing

The Refugee Resettlement Program is staffed by 33 line and supervisory personnel and 7 clerical and administrative support staff. Annual salary costs are $900,615.

Trends

Changes in eligibility rules at the end of fiscal year 1981/82 reduced the amount of time refugees can receive assistance under this program from 36 months to 18 months. As a result, 800 adult refugees shifted to the General Assistance roles in 1982/83. Federal support while on GA continued for up to an additional 18 months. National refugee policy has continued to be restrictive and there exists a considerable national debate relative to refugee policy. Enactment of pending Federal immigration reform legislation could drastically increase local resettlement programs. Refugee resettlement programs should not be a part of America's public welfare system and hopefully, forthcoming Federal policy will significantly change past policies.

GENERAL ASSISTANCE (GA)

Program Description

General Assistance is designed to provide assistance to indigent persons who are in need of short-term financial aid. The programs was restructured in June 1981 to permit a work program and in-kind assistance in lieu of cash. Most recipients are single persons between 18 and 64 years of age. The program is mandated by State law but without funding or regulation.

Funding

General Assistance is 100% County funded at an annual cost of $22 million.

Staffing

Salary costs are $2.3 million annually for a staff of 82 line and supervisory and 24 support personnel. The program is in process of reclassifying line and supervisory personnel at a savings of $300,000.

Trends

The General Assistance caseload has risen consistently over the past two years. Changes in the general characteristics of recipients have resulted in a reversal of previous profiles in that 55% of recipients are classified as unemployable because of temporary or permanent disability. Efforts continue to transition needy homeless persons into the GA program.

Several new projects are in development including a photo ID card, direct cash issuance and advocacy enhancement for potential SSI recipients. Clearly, Federal policy which eliminated over 600,000 disabled from SSI has impacted our county with 2,200 individuals currently receiving GA while their claims for disability benefits are appealed at the Federal level. Pending SSI status cases necessitate our county expending in excess of $7 million and must be transferred back to the Federal system. The Mayor has asked her fiscal advisory committee to assist the Department in a total program review and recommendations for changes in county policies.

SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES

GENERAL ASSISTANCE CASELOADS AND EXPENDITURES/FISCAL YEARS 1980/81 to 1983/84

	1980/81			1981/82			1982/83			1983/84		
	Cases Handled	Cases Paid Aid	Expenditure	Cases Handled	Cases Paid Aid	Expenditure	Cases Handled	Cases Paid Aid	Expenditure	Cases Handled	Cases Paid Aid	Expenditure
July	4,705	3,834	$ 879,535	4,988	4,278	$ 912,510	6,368	5,181	$ 1,154,437	7,760	6,754	$ 1,522,138
Aug	5,101	4,158	921,262	6,679	6,286	1,154,610	6,679	6,286	1,283,718	7,866	6,977	1,668,262
Sep	5,095	4,266	836,963	4,353	3,656	977,473	6,647	6,026	1,307,966	7,438	6,694	1,630,179
Oct	5,520	4,747	998,695	4,206	3,668	948,291	6,959	5,953	1,329,589	8,893	7,193	1,752,297
Nov	5,637	4,855	844,175	3,806	3,469	842,102	6,922	6,527	1,337,200	8,559	7,644	1,850,133
Dec	5,863	5,068	994,469	3,801	3,373	892,116	6,842	6,223	1,347,001	8,736	7,741	1,848,149
Jan	5,990	5,094	1,054,578	3,734	3,189	856,854	7,112	6,526	1,388,975	8,515	7,904	1,979,535
Feb	5,935	5,040	927,565	3,752	2,879	816,666	7,211	6,470	1,268,534	8,224	7,497	1,737,172
Mar	6,090	5,144	1,093,139	4,007	3,446	946,064	7,549	6,779	1,299,616	8,391	7,788	1,818,366
Apr	6,089	4,931	1,009,899	4,022	3,227	943,886	7,688	6,904	1,496,144	8,176	7,501	1,689,744
May	4.943	3,967	972,469	4,505	3,681	1,065,747	7,589	6,773	1,422,237	7,836	7,173	1,766,505
June	4,862	3,530	842,316	5,027	4,191	1,242,179	7,641	6,781	1,495,006		Not Available	
Total	65,830	54,634	$11,375,065	51,188	44,044	$11,598,498	85,207	76,429	$16,130,423	87,356	80,866	$19,262,480*
Ave/Mon	5,486	4,553	$ 947,922	4,266	3,670	$ 966,542	7,101	6,369	$ 1,344,202	7,941	7,351	$ 1,751,135

* Annualized at $21,013,620

Source: GR237 General Relief Monthly Caseload and Expenditures Statistical Report

NON-ASSISTANCE FOOD STAMPS (NAFS)

Program Description

The Food Stamp Program issues benefits to 15,000 households who are not linked to a cash assistance program. Twenty thousand persons are served each month. The program is federally mandated. Over $20 million of benefits are provided each year.

Funding

The funding for this program is 50% Federal, 25% State, and 25% County.

Staffing

Eighty line and supervisory and 27 support and administrative staff operate the program at an annual cost of $2.2 million.

Trends

The Non-Assistance Food Stamps caseload has experienced a slight decline primarily due to implementation of monthly income reporting requirements in February, 1984. On-line issuance of benefits became operational in the fall of 1983 as did staggered issuance of benefits over the first ten days of the month. These two programs have virtually eliminated duplicate benefit payments and long lines at the outlets and have resulted in improved management control and reconciliation. Clearly, this $14 billion national program must be re-thought especially in light of our mounting Federal deficit. Federal/Sate regulations are, at best, inane and administration is nearly impossible.

SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES

FOOD STAMPS PROGRAM CASELOADS AND EXPENDITURES REPORT

1982/83

	PUBLIC ASSISTANCE		NON-ASSISTANCE		TOTAL		TOTAL PERSONS	TOTAL DOLLAR BENEFITS
	CERT.	PART.	CERT.	PART.	CERT.	PART.		
Jul	9,877	9,746	14,065	13,655	23,942	23,401	50,458	$ 1,575,915
Aug	9,866	9,754	14,343	14,027	24,209	23,781	50,962	1,605,807
Sep	9,855	9,696	14,078	13,849	23,933	23,545	50,709	1,572,559
Oct	9,919	9,842	14,144	13,889	24,063	23,731	50,933	1,818,208
Nov	9,877	9,830	14,125	13,885	24,002	23,715	50,986	1,822,558
Dec	9,902	9,723	14,055	13,571	23,957	23,294	50,427	1,837,842
Jan	9,918	9,743	14,486	13,921	24,404	23,664	51,017	1,862,434
Feb	9,897	9,756	14,560	14,023	24,457	23,779	51,029	1,888,131
Mar	9,938	9,730	14,991	14,514	24,929	24,244	51,786	1,922,596
Apr	9,980	9,794	14,811	14,286	24,791	24,080	51,497	1,899,922
May	9,995	9,834	14,559	13,939	24,554	23,773	51,329	1,893,648
Jun	9,971	9,764	14,225	13,606	24,196	23,370	50,835	1,857,826
Total	118,995	117,212	172,442	167,165	291,437	284,377	611,968	$21,557,446
Ave.	9,916	9,768	14,370	13,930	24,286	23,698	50,997	$ 1,796,454

Percent of certified who participate:
Public Assistance - 98.5%
Non-Assistance - 96.9%
Total - 97.6%

Average benefit per household per month	$75.81
Average benefit per person per month	$35.23

1983/84

	PUBLIC ASSISTANCE		NON-ASSISTANCE		TOTAL		TOTAL PERSONS	TOTAL DOLLAR BENEFITS
	CERT.	PART.	CERT.	PART.	CERT.	PART.		
Jul	9,909	9,704	13,797	12,980	23,706	22,684	50,073	$ 1,835,673
Aug	9,926	9,708	13,610	12,690	23,536	22,398	49,825	1,810,317
Sep	9,926	9,699	13,078	12,094	23,004	21,793	48,848	1,684,812
Oct	9,894	9,458	12,936	11,377	22,830	20,835	45,763	1,649,193
Nov	9,887	9,525	12,732	11,309	22,619	20,914	46,839	1,662,767
Dec	9,674	9,367	12,617	11,533	22,291	20,900	46,014	1,645,596
Jan	9,576	9,270	12,599	11,449	22,175	20,719	43,670	1,623,706
Feb	9,531	9,250	12,412	11,225	21,943	20,475	45,798	1,630,165
Mar	9,626	9,350	12,571	11,293	22,197	20,643	45,798	1,646,425
Apr	9,522	9,263	12,635	11,368	22,157	20,631	46,019	1,645,285
May	9,448	9,196	12,382	11,231	21,830	20,427	45,904	1,631,424
Jun				Not Available				
Total	106,919	103,790	141,369	139,629	248,288	243,419	514,641	$18,465,364
Ave.	9,720	9,435	12,852	12,694	22,572	22,129	46,786	$ 1,678,669

Percent certified who participate:
Public Assistance - 97.1%
Non- Assistance - 98.8%
Total = 98.0%

Average benefit per household per month	$75,86
Average benefit per person	$35.88

Source: DPA 256 Participation and Coupon Issuance Report - Food Stamps
DPA 296 Food Stamp Program Monthly Caseload Movement Statistical Report

SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES

FOOD STAMPS PROGRAM CASELOADS AND EXPENDITURES REPORT

	1980/81								1981/82							
	PUBLIC ASSISTANCE		NON-ASSISTANCE		TOTAL		TOTAL PERSONS	TOTAL DOLLAR BENEFITS	PUBLIC ASSISTANCE		NON-ASSISTANCE		TOTAL		TOTAL PERSONS	TOTAL DOLLAR BENEFITS
	CERT.	PART.	CERT.	PART.	CERT.	PART.			CERT.	PART.	CERT.	PART.	CERT.	PART.		
Jul	10,520	10,305	15,568	13,948	26,088	24,253	51,591	$1,637,882	10,518	10,340	13,949	13,681	24,467	24,021	50,729	$ 1,579,381
Aug	10,572	10,381	15,186	14,400	25,758	24,781	52,775	1,689,400	10,542	10,339	13,737	13,526	24,279	23,865	50,701	1,578,078
Sep	10,453	10,224	14,204	13,445	24,657	23,669	50,550	1,344,309	10,488	10,353	13,473	13,250	23,961	23,603	50,621	1,557,806
Oct	10,439	10,210	14,754	13,924	25,193	24,134	51,097	1,369,210	10,543	10,375	13,619	13,425	24,162	23,800	50,794	1,573,288
Nov	10,435	10,173	14,440	13,668	24,875	23,841	50,468	1,331,546	10,556	10,286	13,056	12,828	23,612	23,114	49,596	1,467,369
Dec	10,311	10,083	14,557	13,810	24,868	23,893	50,254	1,318,463	10,312	10,143	13,250	13,054	23,562	23,197	50,029	1,497,628
Jan	10,422	10,191	14,868	14,051	25,290	24,242	50,699	1,791,383	10,287	10,116	13,221	12,611	23,508	22,727	49,291	1,476,495
Feb	10,371	10,242	14,692	13,910	25,063	24,152	50,632	1,777,298	10,285	10,111	13,391	13,136	23,676	23,247	50,114	1,519,100
Mar	10,463	10,355	14,947	14,420	25,410	24,755	51,697	1,827,343	10,371	10,244	13,820	13,478	24,191	23,722	50,969	1,548,940
Apr	10,429	10,336	14,592	14,032	25,021	24,368	51,115	1,796,513	10,307	10,144	13,904	13,531	24,211	23,675	50,968	1,561,407
May	10,278	10,110	14,219	13,637	24,497	23,747	50,066	1,751,263	10,045	9,939	13,349	13,000	23,394	22,939	49,833	1,549,139
Jun	10,275	10,165	14,122	13,587	24,397	23,752	50,143	1,759,212	9,985	9,872	13,750	13,523	24,888	23,395	50,399	1,569,324
Total	124,968	122,775	176,149	166,832	301,117	289,587	611,087	$19,393,822	124,239	122,262	162,519	159,043	286,758	281,305	604,044	$18,477,955
Ave.	10,414	10,231	14,679	13,903	25,093	24,132	50,924	$ 1,616,152	10,353	10,189	13,543	13,254	23,897	23,442	50,337	$ 1,539,830

1980/81

Percent of certified who participate:
Public Assistance - 98.2%
Non-Assistance - 94.7%
Total - 96.2%

Average benefit per household per month $66.97
Average benefit per person per month $31.74

1981/82

Percent of certified who participate:
Public Assistance - 98.4%
Non- Assistance - 97.9%
Total - 98.1%

Average benefit per household per month $65.69
Average benefit per person per month $30.59

Source: DPA 256 Participation and Coupon Issuance Report - Food Stamp Program
DPA 296 Food Stamp Program Monthly Caseload Movement Statistical Report

MEDI-CAL

Program Desceription

Medi-Cal is designed to assist individuals in meeting their health care needs. Benefits to eligible persons include treatment by health care professionals, in-patient and out-patient hospital care, convalescent home care and prescription drugs. Eleven thousand persons per month are served by the program.

Funding

The funding for this program is 50% Federal and 50% State.

Staffing

Medi-Cal has a staff of 62 line and supervisory and 20 support personnel costing $1.7 million annually.

Trends

The Medi-Cal program experienced a cut of 55% of its caseload on January 1, 1983 as a result of the State's elimination of the Medically Indigent Adult program which served 13,000 recipients in San Francisco. These persons now receive medical care at the county hospital. The withdrawal of medical care for our indigent population was a most drastic policy change and established a dangerous precedent in the manner in which the health care needs of the poor are met. Given rising medical costs we are all medically indigent should catastrophic illness befall us - we must move toward a nationalized system of health care for all of our citizenry.

FOSTER CARE (FC)

Program Description

Foster Care provides assistance to children residing in foster homes or institutions. At present, 1,300 children are aided - 900 in foster homes and 400 in institutions. The Foster Care Program is mandated by State and Federal law.

Funding

FC is 95.&% State and Federally funded and 4.3% county money. Annual expenditures are $14 million.

Staffing

Twenty-one line and supervisory staff and two support staff comprise this program at a cost of $505,000.

Trends

With the passage of PL96-272 (Child Welfare & Adoptions Assistance Act of 1980) and State enabling legislation, SB 14, considerable change is taking place with the foster care arena. Preventive service mandates are having significant impact on re-uniting families and preventing shelter admissions but, current trends see many more seriously disturbed children and families impacting our system. County conflict with the intent of PL94-142 (Education of All Handicapped Children Act of 1975) and our school district's responsibility for learning disabled children continue to be debated. Local mental health programs for children continue to be seriously underfunded and there is hope for additional funding from both the school district and mental health for seriously disturbed children needing short-term out-of-home care. This year will see mandated foster parent training within the county.

FAMILY & CHILDREN'S SERVICES (FC&S)

Program Description

Family & Children's Services provides protective and meergency intervention services for children in crisis. FSC makes placements in foster homes and institutions and serves as the county adoption agency. Additionally, the program sets the rates for, and monitors foster homes and institutions in the county. Andrew Jackson School offers a stable educational environment for children in emergency shelter. All of the activities of Family & Children's Services are mandated by Titles XX and IV of the Social Security Act.

Funding

Seventy-five percent of funding for this program is provided by Federal subvention, the balance county tax dollars. The county has over-matched Federal allocations in this program for several years.

Staffing

Family & Children's Services is staffed by 122 line and supervisory workers and 29 support and administrative personnel at an annual cost of $3.8 million.

Trends

Family & Children's Services continues to focus its efforts on family reunification and preventive services. The tremendous increase in the number of children brought into emergency shelter as a result of abuse, neglect and abandonment has required an increase in crisis intervention services. A 24-hour, 7-day-a-week emergency service team deals with this problem in coordination with Children's Home Society. Implementation of SB 14 has resluted in drastically increased workloads.

The program is is process of devloping a comprehensive automated reporting system.

Current shelter care referrals continue to exceed the planned 75 per month and have been averaging in excess of 140 per month. Recent rends have included many more under age five youngsters as wellas a generally more seriously disturbed population. We are fortunate to have the competence, dedication and creativity of Children's Home Society. Retraining of DSS staff continues That DSS' Child Welfare Division began permanency planning and family reunification three years before legislative enactment put San Francisco far ahead of others and its innovative and dedicated staff can be justifiably proud of their admirable and much appreciated efforts and accomplishments.

ADULT SERVICES

Program Description

The Adult Services program provides in-home supportive services (IHSS), placement, protective services, and information and referral services to the aged, blind and disabled. Through its Volunteer activity, the program operates a clothes closet and supervises the AFDC children's playroom. The caseload is approximately 6,000, most of whom receive in-home supportive services. All of the activities of the Adult program are mandated by Title XX of the Social Security Act.

Funding

Funding for Adult Services is provided by a closed-end allocation of Federal funds from the State Department of Social Services.

Staffing

Adult Services and Information Referral Resource Services are staffed by 72 line and supervisory workers and 13 support at an annual cost of $2.1 million.

Trends

Adult Services is working toward increased usage of contractual services rather than individual providers to provide in-home supportive services. It is felt that better utilization of hours and dollars available will result from this plan. Passage of Elder Abuse Reporting legislation is changing the focus and level of protective services activities. The focus of DSS this year and next will be to implement in Adult Services much of what has been implemented in our Family and Children's Division over the past 6 years. Extensive program implementation is scheduled for DSS Adult Services this coming year. Extensive expansion of DSS Volunteers will be initiated this fiscal year.

ADMINISTRATIVE SERVICES

Program Description

This division provides all of the administrative support necessary to keep the Department operating including Personnel and Payroll, Staff Development and Training, Contracts, Program Evaluation, and Support Services.

Personnel and Payroll is responsible for all Civil Service related activities and includes an outstanding testing unit which gives examinations for classifications utilized by the Department. Staff Development provides for in-service training and is mandated by State regulation. The Contract Program Evaluation is responsible for data analysis, handbook development and fair hearings. Some of its activities, such as quality control, are required by Federal and State regulation. Finally, the Support Services division provides for physical plant maintenance, purchasing and processing, printing, fleet and equipment maintenance, and mail services.

Funding and Staffing

The Administrative Services program is that gorup whose costs are allocated among the income maintenance and service programs. Generally, 75% of all expenditures are subvented by State or Federal funds. A total of 219 people provide support services.

FISCAL SERVICES

Program Description

The Fiscal Division is responsible for issuing and controlling all negotiable instruments, cashier services, accounts payable, and State claim preparation. In addition, the program acts as liaison to the Family Support Bureau for application of child support payments.

Funding and Staffing

The staff of 71 at an annual cost of $1.5 million, is subvented at a 50% federal, 25% State and 25% county cost.

SPECIAL INVESTIGATIONS UNIT

Program Description

The Special Investigations Unit is responsible for processing claims for overpayments of aid, for arranging repayment agreements, and for collecting repayments. It also develops cases for referral to the City Attorney and District Attorney for civil and criminal fraud prosecutions.

Funding and Staffing

Funding for this activity varies with the type of claims handled with some staff charged as a general administrative expense. The SIU is staffed with 26 line and supervisory workers and 8 administrative support.

Trends

The SIU has worked over the past year to eliminate several thousand uncollectable claims and to streamline its operations. Recent changes in Food Stamps overpayment and collection regulations are in process of being implemented which will make effective collection more difficult.

HOMELESS PROGRAM

Program Description

The Homeless Program provides a temporary emergency shelter to individuals and families who have no place to stay as a result of eviction and/or destitution. Recipients are assisted in finding permanent housing and in applying for public assistance benefits so that they may have income to pay for housing. In concert with the private, non-profit shelters with which the Department contracts, over 1200 persons per night are provided shelter.

Funding

Funding is provided from the General Assistance Program, the Homeless Program, AFDC, and the Mayor's Fund for the Homeless. Clients who have a source of income are required to pay for a share of the cost.

Staffing

Established as a new program this year, the program has five administrative staff and 36 line workers at a cost of $1 million.

Trends

Since its inception in November 1982, the Homeless Program has gone through several transition stages and has generally stabilized. 900 persons are housed in eight hotels, 340 in shelters and 175 families in hotels each night. Efforts are now focused on stabilizing the life styles of clients by emphasizing support services including finding permanent housing, assisting with rental deposits, and advocating for those who appear eligible to federal SSI benefits.

PREPARED STATEMENT OF SAM KARP, ADMINISTRATOR, FOOD AND NUTRITION SERVICES, INC., REPRESENTING THE NORTHERN CALIFORNIA ANTI-HUNGER COALITION

Congressman Leland and members of the select committee: Good morning, my name is Sam Karp. I work with Food & Nutrition Services, Inc., a community based service provider and advocate for nutrition, transportation and health programs serving poor, working and elderly residents of Santa Cruz, San Benito and northern Monterey Counties. I am here today representing the northern California Anti-hunger Coalition.

Thirty-eight years ago, Major General Lewis Blaine Hershey, then Director of the Selective Service System, testified before Congress that 70 percent of men who had been rejected for induction during the Second World War had suffered from malnutrition as children.

Congress responded to General Hershey and others by enacting the National School Lunch Program as ". . . A measure of national security."

Today, thirty-eight years later, we have a nutritional crisis in America that, once again, threatens our national security. And, unless we are prepared to act quickly and decisively, hunger will rapidly become another American institution.

Hunger is not a new phenomenon in America. What is most frustrating about its resurgence, though, is that it is a problem we know how to solve, but don't. America remains in full retreat from any national food policy.

It has been said that the measure of a society is how well it treats it children and its elderly.

Today, children are the poorest age group in America. They are most likely to suffer sickness and death, hunger and cold, abuse and neglect. Children are more likely than they were several years ago to be victims of inadequate prenatal care, and less likely to be immunized and have access to preventive health and dental care, and to receive special education services.

One in five American children is poor, one in two black children is poor, and two in five Hispanic children are poor.

Today, our elderly live with the fear of being warehoused in nursing homes, rather than living out their years in their home and community environment with the respect and dignity they deserve. And the cost of illness is becoming the highest price that Americans pay for growing old.

This hearing today represents a step forward. After a solid year of hearings and countless reports, we have finally moved beyond questioning the existence of hunger and we can now get to work on solving the problem.

I have been asked to provide you with an overview of the national nutrition programs and to discuss the adequacy of the benefits and the effects of various regulatory changes and budget reductions. I will begin with the elderly nutrition programs.

Two Federal nutrition programs address the special needs of America's elderly: Congregate Meals and Home Delivered Meals.

The Congregate Program provides nutritionally balanced meals and affords opportunities for social interaction and companionship.

The Home Delivered Meals Program provides meals to those who are homebound by reason of illness or incapacitating disability, or who are otherwise isolated.

The most recent health and human services evaluation of nutrition services for the elderly was published in May of 1983, as a follow-up to a similar evaluation first conducted in 1976. The major findings of the evaluation state:

While these is no means test, the program does effectively target those elderly who are socially and economically disadvantaged.

Three-quarters of the program participants are considered priority participants by virtue of advanced age, low income, minority status, isolation, mobility impairment or the limited ability to speak English.

Voluntary contributions by program participants totalled $117 million in fiscal year 1983.

Nevertheless, the effectiveness of these program could be improved significantly without major programmatic restructuring.

The level at which funding is appropriated for both programs is seriously inadequate. Nationwide, only 9 percent of the eligible population is being served. Here in California 4,000 senior citizens are turned away each day at congregate meal sites, and 9,000 others are on waiting lists to receive home delivered meals.

Participation by minority elderly here in California, as across the Nation, has been steadily declining. Barriers which inhibit equal access must be removed. This can best be accomplished with additional monies targeted to culturally sensitive outreach efforts as well as intensified efforts in the areas of affirmative action, minority contracting and greater service targeting to reach those who live in the highest incidence of poverty.

We are also now experiencing a statewide pattern of increasing requests for home delivered meals. It is our belief, based on conversations with nutrition program directors and hospital administrators, that this increase can be attributed, in part, to Federal attempts to contain rising hospital costs through medicaid and medicare reform. With the phase-in of hospital payments on the basis of diagnostic related groups (DRG's), we are finding an increase in the early release of senior citizens from acute care. Many of these patients are in immediate need of home delivered meals during their home convalescence.

The California Department of Aging has estimated that 5,000 elderly Californians reside in nursing homes simply because they could not provide for their daily nutritional needs. That figure represents five percent of California's nursing home population.

Americans 85 and older make up the fastest growing population group in the United States. Their numbers are expected to double by the year 2000 and rise even more rapidly in the next century. Because of multiple chronic illnesses that people 80 and older face, they consume on average, 77 percent more medicare benefits than the "newly" old.

It is this growing population that an expanded Home Delivered Meals Program will benefit most greatly. And it is our entire society that benefits by the enhanced quality of life for our elders.

The National School Lunch and Breakfast Programs provide financial assistance to schools so that students can receive a nutritious lunch and/or breakfast. The program enables low-income students to get meals at no cost or for a reduced price, and allows the schools to charge other students somewhat less than the full cash of the meals.

Budget cuts have forced 650 schools to drop out of the breakfast program, and over 2,000 schools have dropped the lunch program. Between fiscal year 1980 and fiscal year 1983, there and a half million children, including over one million low income children, no longer receive a lunch.

The School Lunch and Breakfast Progam in California, once a model for the Nation, is being decimated by reduced staff, diminished quality and variety of meals, and increased meal costs. Over the last two years, 77 million meals home been dropped here in California. This amounts to over 425,000 meals each school day, each meal representing one child.

80 out of 1,100 California public schools have dropped the lunch and breakfast programs entirely because they cannot make ends meet. Poor children, who have depended on the lunch program for between 34 to 49 percent of their daily nutritional requirements, have little chance to compensate when they don't get a lunch.

New rules, which require schools to verify parents' income in order to establish school meals eligibility, are having a chilling effect on the participation of children. Los Angeles has reported a 40 percent non-return rate on verification forms due to the complication from the inability of some parents to read English, and general apprenhension in non-U.S. citizen parents.

While we have 90,000 schools nationwide participating in the school lunch program, only 33,000 schools offer breakfast programs to children. A 1980 GAO study found that the major factor which inhibits schools from sponsoring breakfast programs is that reimbursement rates too low, as actual costs far exceed the rate of reimbursement.

New incentives are needed to encourage schools to open breakfast programs. And, should we not legislatively require that schools which serve 20 percent or more free or reduced priced lunches to also offer breakfast programs. For if our future is not our children, what future do we have.

The Summer Food Service Program for children is designed to feed children up to 18 years of during the summer months when school food services are not available. The program is aimed at low income children and meals offered without charge.

In 1981, the administration attempted to eliminated the Summer Food Service Program. These attempts failed. However, the administation was successful in excluding private nonprofit agencies from contracting to provide services under this program.

This change alone accounted for a daily drop in nationwide participation of 500,000 low income children. In California, during the same period, 14,000 children lost access to summer meals. And here in San Francisco 62 sites were closed, and nearly 6,000 children a day were denied meals. Between 1980 and 1983, the total number of summer meals served in California were down by nearly $2 million.

In fiscal year 1983, summer meals nationwide, in California and in San Francisco are up from 1982 levels, but they are still far below the number of meals served in 1981. We would strongly urge that private nonprofit sponsors again be allowed.

The Child Care Food Program (CCFP) provides reimbursements to licensed child care centers and family day care homes for meals served to children in their care.

There is substantial evidence of the nutritional importance of CCFP. A recent Department of Agriculture evaluation of the nutritional impact of the program found that:

For every measure examined, participating child care centers and family day care homes have statistically significantly higher levels of meal quality and variety than nonparticipating centers and homes.

The need for accessible, high quality and affordable child care is increasing daily. Over 40 percent of mothers or one year olds work. 57 percent of mothers of children between three and five also work. The Child Care Food Program helps to keep child care affordable for these parents.

A recent California State Department of Health Services study found that access to child care was the single most important factor in reducing repeated teenage pregnancies when combined with helping mothers get back into school. The Child Care Food Progrm also assists parents by requiring providers of day care to be licensed, thereby assuring a minimum standard of care.

In fiscal year 1982, funding for the program was cut 30 percent, or $130 million.

As a result, 41 percent of California programs have reduced meals, and 14 percent have dropped out of the program. For many children who spend up to 12 hours a day in a child care center or family day care home, the result has been a cut from three meals a day to two, and from two nutritious snacks to only one.

What can be done legislatively:

1. Restore the $130 million which curtailed the nutritional adequacy and scope of the program.
2. Establish an outreach requirement with adequate funding for State and local agencies to bring more homes and centers into the program.
3. Establish a tax credit system for private industries which open their own day care facilities that participate in the Child Care Food Program.

I know that earlier this morning you were scheduled to visit a service delivery site of the Women, Infants & Children's Program (WIC) and later this morning you will hear compelling testimony from Doctors Castillo and Mendoza. However, I do want to briefly mention the importance of the WIC program.

The goal of WIC is to improve the health of women and children during pregnancy and the post-partum period, infancy and early childhood. The program is both remedial and preventive. It provides nutritious foods and nutrition education to an already at-risk population.

Numerous studies and USDA evaluations have made WIC the most studied and conspicuous public health program of its size. The most recent study, conducted by the U.S. General Accounting Office (GAO) was done at the request of Senator Helms, and this study found that there is strong evidence that WIC does improve the outcome of pregnancy in terms of reducing the incidence of low birth weight.

Despite this proven record of success and strong bipartisan support, the WIC program does not have entitlement status. Each year, the program must spend within a finite appropriations ceiling, and WIC currently serves less than one-third of the estimated eligible population nationwide. California serves only 21 percent of those eligible.

The existence of waiting lists and the priority system of caseload management, while designed to meet the medical and nutritional needs of those at greatest risk, seriously compromises the preventive goals of the program, and still leaves others who are at some risk without needed assistance.

Given the time limitations of this hearing, I cannot begin to do justice to the many concerns we have within the Food Stamp Program. I do want, however, to tell you that the Food Stamp Program has been, and continues to be, the most effective single program in improving the nutritional status of low income families in America.

Repeated studies, again both private and government sponsored, and testimony from food stamp recipients and emergency food providers alike, speak to the insufficient level of food stamp benefits. Many recipients run out of food stamps by the last two weeks of the month. Food stamps are not a luxury for the poor. They are intended as a minimum monthly survival ration, and they ought to last a month.

Since 1981, there have been over 95 separate legislative changes in the Food Stamp Program. Forty percent of these changes modified eligibility requirements or benefit levels.

As advocates, we are distresed by the inherent, inadequate level of benefits, and with the apparent adverse effects of monthly reporting/retrospective budgeting, and the proposed error rate sanctions and madatory work registration/job search requirements. Our goal must be to increase access and to provide adequate benefits. I am afraid we are moving in the wrong direction.

Many critics of the Food Stamp Program claim that the program is plagued by fraud and abuse. The most reliable USDA data revealed that in 1983, about 20,000 food stamp recipients (out of an average caseload of 21.6 million) were found to have committed fraud. Food stamp fraud involved less than one/100th of one percent of all recipients and about 17/100's of one percent of total program benefits.

I understand that you will be discussing the status of monthly reporting/retrospective budgeting (MRRB) on the floor next week. We urge you to repeal this requirement.

MRRB was intended to save money in overpaid benefits. Several recent studies show that this new system is actually costing money instead.

Preliminary results of a yet-to-be released study begun in 1981 in Illinois showed that in the first six months of monthly reporting, both benefit and adminstrative costs rose.

The Federal Government's own study estimated that monthly reporting could be expected to increase administrative costs by at least 5 percent without necesarily providing any savings in benefits.

The Illinois study also showed that nearly all recipients dropped from the program under the new rules were still poor enough to qualify but simply not deal with the paper work.

In New Jersey, where average food stamp benefits are about $43 a month, welfare officials estimate that monthly reporting costs an extra $25 a month to process each case. In New York City the increased cost is $7.53 per case and in North Carolina nearly $10 per case.

Presidential Advisor Robert Carlson recently said that "All recipients have to do is to fill out a simple little form." In New Jersey, that form is four pages long and some have likened it to filling out a monthly income tax return.

Again, we urge you to repeal MRRB. Its principal effect has been to deny access to those in need, while creating more red tape and cost.

I said earlier that hunger threatens our national security. After years of slow but steady progress, the momentum has shifted against us.

We hear much talk about national security. And in the past three years those of us in human services have witnessed a massive transfer of billions of dollars from programs serving people to the military. But surely the defense of this nation depends on the health of our children as much as on the size and number of missiles. It must mean freedom from hunger for our own citizens at least as much as military intervention in central America.

The cost of the military aid to El Salvador alone in the last year is three times the budget for nutrition programs for our Nation's elderly.

The five billion dollars budgeted in fiscal year 1985 for the development of the MX missile could instead increase the participation and benefits in the food stamp program by 50 percent, which would be a giant step toward eliminating hunger.

We have learned to live in a culture of haves and have nots. We co-exist with inequalities, and teach our children the survival techniques of dulled sensibilities—we walk around certain people, avoid "bad" neighborhoods, and comfort ourselves with the notion that our Government is somehow, somewhere helping. But there is a point, when we wonder out loud whether we have become too good at not noticing.

A positive program to end hunger in America will not be forthcoming until we begin to reorder our Nation's priorites so that, once again, people matter.

Thank you.

PREPARED STATEMENT OF FERNANDO MENDOZA, M.D., M.P.H. AND RICARDO O. COSTILLO, M.D., M.P.H., DEPARTMENT OF PEDIATRICS, STANFORD UNIVERSITY SCHOOL OF MEDICINE

The nutritional status of children is one of the primary indicators of overall health status. Those children who demonstrate inadequate nutrition have been shown to have: poor somatic growth; poor disease response; inadequate growth of rapidly growing organs (such as the brain which in turn can lead into problems of development); and behavioral alternation, such as short attention spans, apathy, or even antisocial behavior. Furthermore, there seems to be critical periods during childhood where the effects of poor nutrition can have the most devastating effects on the child. This period occurs during the first five years of life where growth and development are most rapidly changing. It is, therefore, vital to provide good nutrition during this critical time in childhood.

Studies examining the growth of Mexican-American children have persistently indicated lower height and weight among this population as compared against the population at large. There has been some controversy about whether these findings are secondary to genetic background or socioeconomic status. More recent information seems to indicate that these observed differences in growth are secondary to socioeconomic status rather than genetic background.

We have just completed a preliminary study of a national sample which suggest that the children at greatest risk for these growth problems are those whose families are below the poverty line. Once the family income was one and a half times above the poverty line, these growth differences were no longer present. This strongly suggests that correlations of low socioeconomic status can influence the growth of Mexican-American children. The socioeconomic factor involved possibly includes: (1) nutritional intake which encompasses not only the quantity but also the quality of the food, (2) exposure to infectious diseases, which can affect nutritional status by decreasing intake and increasing needs, and (3) contact with health care services and education program which provide not only preventive but also diagnostic service.

Therefore, there seems to be an association between growth abnormalities among Mexican-American children and their families' socioeconomic status. These families below the poverty line have children with significantly affected weights and heights. Though these studies, including ours, have been done with data from the early 1970's, the same association will possibly continue to be true in the 1980's. Moreover, the 1980 census has noted that 30% of the Mexican-American population is below the poverty line. This would seem to indicate that these problems are possibly still common.

We recommend, therefore, that policy directed at improving the nutritional status of Mexican-American children include two major goals. First, to obtain improved and continuous information on the nutritional status of Mexican-American children. Second, since children cannot wait for future studies, because the critical period for them may be now, continued support of nutritional programs should be strongly recommended.

PREPARED STATEMENT OF ARISIKA RAZAK, M.P.H., C.M.N., DIRECTOR, PROJECT FOR THE PREVENTION OF PRE-TERM DELIVERY

The problem of low birth weight infants—infants born weighing less than 5½ pounds is the single most critical problem in obstetrics today, for infant birth weight is the most crucial determinant of subsequent infant survival and well being. Now birth weight infants are 20 times more likely to die within their first year as are normal weight babies. And very low birth weight infants (infants weighing less than 3½ pounds) are 300 times more likely to die in their first 28 days of life as are normal weight babies.

Additionally, low birth weight is associated with an increased occurrence of mental retardation, learning disabilities, birth defects, blindness, autism, cerebral palsy, epilepsy, growth problems, visual and learning defects, delayed speech, and chronic lung problems. According to the U.S. Surgeon General "low birth weight is the greatest single hazard for infants, increasing their vulnerability to developmental problems and to death". (Public Advocates: Administrative petition to reduce the incidence of low birth weight and resultant infant mortality).

Infant weight at birth is highly dependent on the mother's nutritional status before and during her pregnancy. Poorly nourished women whose pre-pregnancy weight is less than normal and whose diets continue to be inadequate are more likely to have a low birth weight and growth retarded baby than are adequately nourished women of normal prepregnancy weight. Women who gain less than 10 pounds in the first 26 weeks of their pregnancy or who lose more than 5 pounds during the pregnancy are also at greater risk of having a premature baby—and prematurity accounts for about 2/3 of all low birth weight infants.

Continuing nutritional deficits in pregnancy increase a women's vulnerability to illness and infection—and illness and infection are themselves associated with prematurity and low birth weight. Toxemia, or pre-eclampsia, for example, is associated with the production of low birth weight and growth retarded infants. In its most severe form it can lead to maternal and infant death. Many authorities feel toxemia is associated with inadequate protein consumption, and the standard medical treatment for women exhibiting signs and symptons of pre-eclampsia includes diet modification and nutritional counselling.

Inadequate maternal consumption of iron place the pregnant woman and her unborn at significantly greater risk. And inadequate iron intake can further predispose the pregnant woman to infection, increasing her chance of producing a premature and underweight baby.

Since a baby inside the womb cannot receive more than what its mother takes in, common sense tells us that a well nourished baby needs to have a well nourished mother. But we have more than common sense to tell us this. For the last 35 years, the Montreal Diet Dispensary has been providing milk, eggs, and oranges to low income women attending public prenatal clinics. Significant increases in birth weight for high risk (underweight, poorly nourished and adolescent) women resulted. I have seen a film that depicted a mother served by that project. Without adequate nutritional supplementation, she produced five (5) premature and low birth weight children. Each child had physical or mental handicaps as a result of prematurity and low birth weight. Her only normal child was born full term or more than 37 weeks subsequent to nutritional supplementation by the Diet Dispensary. Her medical care was no different. This kind of preventable waste and loss of human potential cannot be tolerated.

I have worked for the last four (4) years with the Oakland Perinatal Health Project, a project of various county and community clinics, outreach efforts and direct and indirect health care providers. I am here to tell you that comprehensive prenatal care, prenatal care given in conjunction with social services, nutritional services and health education absolutely makes a difference in pregnancy outcomes. And the cornerstone, an most significant non-medical intervention we can make—is through nutritional services. There is no other variable to which high risk pregnant women and their infants respond as readily. There is no other non-medical high risk variable that we can as easily correct.

For example, all of our statistics indicate that certain demographic factors place the woman at high risk. In our County, for example, the infant mortality rate for Blacks has been between 55 and 70 percent greater than the infant mortality rate for whites for the years 1978 and 1982. Black women have an incidence of low birthweight that is roughly twice that of white and Hispanic women and teenaged women have an incidence of low birthweight that is above the County average. This data is not unique to Alameda County, but parallels national data.

Statistics from the Oakland Perinatal Project show that the high risk status of these groups is not genetic, or physiologic. Black women in our project experienced an incidence of low birthweight that was essentially equal to that of white women in the project, (6.2 and 6.1 percent, respectively) and one that was substantially lower than the County average for all women. Teens experienced an incidence of low birthweight that was also significantly lower than the County average (7.2 versus 8.8 percent).

When you ask providers what the variables are that make the difference, nutrition comes up again and again. When you talk to a teen about the reasons she needs to gain more weight, when you provide food supplementation to women who cannot afford it, when you counsel clients about protein equivalents in their non-American diets, you effect change in one of our most significant health care variables. Changing women's nutrition changes their pregnancy outcomes. Our project found that the number of prenatal visits was positively correlated with birthweight increases. There was a 13.6 gram increase in birth weight for each prenatal visit. As head of the midwife service that managed 30 percent of the OPHP Patients. I can personally attest to the fact that increased prenatal visits meant increased nutritional counselling. Women who did not gain weight had interim visits with the nutritionist. They had extra nutrition counselling from the CWM. Referrral to WIC was a standard part of our patient management plan. This was paralleled in clinics throughout the entire Perinatal Project.

We considered food supplementation indispensible. There are many, many women that do not have enough to eat—that need the protein supplementation of WIC. The fact that WIC is tied to health care clinics is a positive encouragement for women who might otherwise be poor clinic attendees. WIC nutrition workers are often perceived by clients as credible sources of health information—their counselling and reinforcement is a welcome adjunct to the efforts of the health care team.

In summary, we need to continue and expand nutritional services to pregnant women. These services are absolutely necessary if we are to successfully reduce the incidence of low birth weight and prematurity. Every dollar spent on nutrition can save $3 in remedial care. In our County, based WIC services, we are approaching the maximum number of patients we can serve. But the need for WIC services is increasing, not decreasing. We need to expand our services—and I'm sure we're not the only county that needs to do sol Ladies and Gentlemen you must act. America's unborn—her future citizens depend on you.

PREPARED STATEMENT OF LOIS SALISBURY, PUBLIC ADVOCATES, INC.

(Prepared with the assistance of Jody Lerner, student, King Hall School of Law, University of California, Davis)

I. INTRODUCTION TO THE HEARING ON HUNGER

On behalf of the minority, womens, health, and childrens organizations represented by Public Advocates, I am pleased to be here today to give testimony before the Select Committee on Hunger. In recent years, Public Advocates has been involved in litigation and other forms of advocacy aimed at the eradication of hunger in America. This involvement has sought the obvious: the rechanneling of this country's vast resources to remove the obstacles preventing low-income people from having access to quality, affordable food.

These attempts have ranged from seeking to halt the exodus of major food chains from low-income communities, to petitioning the FDA for stronger labeling on infant formula cans, to advocating changes in hosptial practices and government funding aimed at providing pregnant women with the resources needed to bring healthy babies into this world. Because of this long involvement, Public Advocates welcomes this opportunity to share the knowledge gained through these activities and to learn from others providing testimony today. We have been asked specifically by the Committee to focus on infant mortality and nutrition.

Public Advocates has been deeply involved in this important issue. We, therefore, gladly embrace this opportunity for major public scrutiny of the causes and solutions to avoidable high infant mortality rates in a country with such enormous wealth and resources.

A brief description of Public Advocates' involvement should be helpful. In June, 1983, representing civil rights, women, and health organizations, Public Advocates filed an administrative petition with the U.S. Department of Health and Human Services. This petition, which focused national attention on high infant mortality among Blacks, seeks national leadership in solving this problem. Specifically, the petition seeks clarification of existing rules, and new rules and policies aimed at providing all poor women with access to comprehensive prenatal care. In addition to the above remedies, the petition also contained an Infant Mortality Survey of 45 diverse U.S. cities. This survey was conducted in conjuction with the University of California at Berkeley School of Public Health and found that in over half of the 45 cities surveyed, IM among Blacks had gone up from 1980–1981. A study of the cost effectiveness of providing prenatal care was also included. I will be happy to provide this Committee with more detailed information at this hearing or by formally submitting the petition into the record.

A. Infant mortality

Infant mortality rates in this country are extraordinarily high. Given the abundance of resources and information available, this rate is unconscionable. For the past 17 years, the U.S. has maintained the unimpressive rank of between 14th and 18th of 25 industrialized nations with the lowest infant moratlity rates.[1] To appreciate the lifesaving impact of an infant death rate which is approximately five points lower consider the following: If the U.S. infant dath rate in 1977, (14.1 per thousand) had been equal to Japan's (8.9), 17,000 fewer American babies would have died that year.[2]

These high infant mortality rates (IMRs) primarily reflect the health of the poor in the U.S. rather than health in the U.S. in general. For example, if between 1978 and 1982, the IMR for Blacks has been equal to that of whites, 19,000 more black babies would have lived.[3]

If one carefully reviews IM data, it becomes apparent that the U.S. possesses the technological know-how to be at the top of the list regarding low infant mortality. Actually, statistics indicate that the United States saves small babies on a par with any country in the world; the infant mortality rate in the U.S. remains high because there are so many small babies to save.

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[1] Hein, Herman A., "Commentary, Secrets from Sweden," 247 J.A.M.A. 985–986 (Feb. 19, 1982)

[2] Wegman, M.E., "Annual Summary of Vital Statistics—1980–81", 68, 70 PED. (Dec. 1981, Dec. 1982).

[3] Food Research and Action Center "The Widening Gap." Jan. 1984

B. Low birth weight

Small or low birth weight (LBW) babies (those weighing less than 5½ pounds) are the greatest contributor to infant mortality. According to a 1980 U.S. Surgeon General's Report, "LBW is the greatest single hazard for infants, increasing their vulnerability to developmental problems and to death."[4] The lower the birthweight, the more likely that the baby will be stillborn or die soon after birth.[5] LBW infants are more than twenty times as likely to die within their first year as normal weight babies.[6] LBW accounts for fully ⅔ of all U.S. infant deahts.[7] LBW has also been connected with increased occurrence of mental retardation, learning disabilities, birth defects, blindness, autism, cerebal palsy, epilepsy,[8] growth problems, visual and hearing defects, delayed speech, and chronic lung problems.[9]

Several factors influence LBW, including race, age of mother, education, poverty, and nutrition. All of these factors are directly related to lack of prenatal care.

1. Prenatal care.—The chances of having a LBW baby are three times as great when an expectant mother receives no prenatal care.[10] Studies confirm a direct correlation between birth outcome and prenatal care. Studies of comprehensive prenatal programs serving low-income women have documented that once brought into the health care system, the benefits go beyond simple detection of medical problems. Once counseled about the changes of smoking, alcohol use and other lifestyle practices which could be harmful, women usually happily make the necessary adjustments.

Alarmingly, the Public Advocates (PA) survey indicates for 1981 a slight decrease in the number of women, Black and white, receiving first trimester prenatal care, and a slight increase in the number of women receiving no prenatal care at all. Technological improvements in the care of LBW infants have contributed most to an overall reduction in infant mortality.[11] But the occurrence of LBW births can only be reduced by increased availability of comprehensive prenatal care. Many obstacles prevent all women in need fom receiving this care.

2. Race.—Nationwide, LBW rates are consistently higher for Blacks than for any other major ethnic group.[12] Not surprisingly, because of poverty and lack of information, Black women are much less likely than white women to receive the early periodic prenatal care necessary to reduce these rates. Public Advocates collected LBW data from 32 cities by race for the years 1978–81. This survey revealed that Black infants are about 2½ times as likely as white infants to be of very LBW and two times as likely to be of LBW.[13]

Locally, the problems are exactly the same. In 1982, data for Contra Costa County show that the LBW rate for Blacks was 121 percent higher than the rate for whites.[14] For Alameda County, the 1982 LBW rate for Blacks (12.3 percent) was 151 percent higher than the rate for whites (4.9 percent). This Black rate increased 7 percent from 1980–81, (11.3 percent to 11.7 percent), and jumped 46 percent from 1981–82 (11.7 percent to 12.3 percent).[15]

3. Teenagers and LBW.—Teenagers are particularly at risk of having LBW babies.[16] For a combination of reasons including fear, they are less likely than other pregnant women to get the early, high-quality prenatal care which could avert many of the damaging health consequences of early childbirth.[17] It is, therefore, disturbing that the Public Advocates' surevey indicated that while the overall teenage pregnancy rate is decreasing, the disparity between Black and white rates seems to be increasing: in 1981, the teenage birth rate was 118 percent higher among blacks than whites.

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[4] U.S. Dept. of Health, Education and Welfare, Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention, PHS NO. 79-55071 (1979).

[5] Korenbrot, C., Comprehensive Prenatal Care as a Medi-Cal Benefit: Expected Costs and Savings," (Contract Report to Maternal and Child Health) (California Dept. of Health Services (Jan. 31, 1982).

[6] U.S. Dept. of Health, Education and Welfare, supra.

[7] U.S. Dept. of Health and Human Services, Better Health for our Children: A National Strategy (Report of the Selection Panel for the Promotion of Child Health to the U.S. Congress and Secretary of Health and Human Services, (1981).

[8] U.S. Dept. of Health, Education and Welfare, supra.

[9] Fine, A., et al, Proposed Child Health Outcome Indicators: Phase I (Jan. 24, 1983).

[10] U.S. Dept. of Health, Education and Welfare, supra.

[11] "Doctors Mull Increase in Sudden Infant Death", Los Angeles Times, July 20, 1984

[12] Johnston, P., "Black Infant Mortality: San Francisco's Little-known Public Health Crisis", San Francisco Bay Guardian, June 13, 1984.

[13] Kleinman, J., "Trends and Variations in Birth Weight," Health, United States, 1981, DHHS, Pub. No. PHS 82-1232 (Dec. 1981).

[14] California State Dept. of Health.

[15] "Alameda County Perinatal Mortality and Low Birthweight Case Control Studies", Alameda County Health Care Services Agency, Management Systems and Analysis, March, 1984.

[16] U.S. Dept. Health, Education and Welfare, supra.

Conditions in California are no better. In 1981, more than 55,000 teenage women gave birth in California. Eleven percent of these pregnancies resulted in LBW babies. The LBW rate for minority teenagers was 17 percent.[18] The California figures for mothers under the age of 15 are even more startling. In 1981, in the 15 and under age group, there were 184 births to whites and 386 births to Hispanics.[19]

4. Poverty.—There is a clear relationship between poverty and low birth weight,[20] and between poverty and higher risk of infant death.[21]

Infant death rates in 50 states and the District of Columbia were found to be higher in areas in which a higher percentage of the population lived below the poverty level.[22] In Michigan, a state which from 1980 to 1981 experienced one of the greatest yearly increases in infant deaths since World War II, the Michigan Department of Health concluded that the rise in IMRs was consistent with poor economic conditions, high unemployment, and unprecedented cutbacks in social services. "The poor, irrespective of race, experience a higher low birth weight rate because of the interactive effects of poor housing, diet, medical care, and related factors."[23]

Many of the factors which are linked to low birthweight—poor maternal nutrition, low educational level, race nonwhite, teenage pregnancies, and unwed mothers—are more predominant in poorer communities. "Put simply, poorer mothers have smaller babies, and smaller babies are at higher risk of early death." [24]

Two-thirds of all people living in poverty are women and children, and the rate is increasing.[25] S.F. alone had 13,020 cases on AFDC in May of this year, and this was only 10 percent of those eligible.[26] The Census Bureau just reported that although Reagan's tax program boosted the income of most Americans, families headed by women were left with less money to spend after taxes in 1982. Households that earned less than $10,000 paid 4.2 percent more in taxes in 1982 than in 1981. All other income groups paid less in taxes in 1982.[27]

5. Environment.—Many of the women with these high risk factors (Black, teenager, living in poverty) live in areas where there is impaired access to remedial resources. Supermarket chains are fleeing the inner cities, forcing residents to shop at smaller, more expensive markets—many of which carry little or no fresh produce. S.F. is one of the nation's most expensive cities in which to live. The high cost of food here further limits the ability to obtain proper nutrition by those with the least money. Yet, as of May 1984, only 11 percent of San Franciscans eligible were receiving Food Stamps (based on 1980 census data).[28]

Also, in these poor areas, advertisements pushing alcohol and tobacco predominate without the presence of counterbalancing information about the harms these substances can cause during pregnancy.

Further, in the last few years, there has been a tremendous growth in the for-profit health care industry.[29] These chains are locating their facilities in the profitable suburbs and away from the inner cities.[30] As medicine becomes more exclusively profit oriented, fewer doctors are willing to treat Medicaid patients.[31] This shift further obstructs poor people's access to necessary health services.

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[17] Allen Gutmacher Institute, "Teenage Pregnancy: The Problem that Hasn't Gone Away", (New York 1981).

[18] Brindis, C., unpublished paper, Center for Population and Reproduction Health Policy, Institute for Health Policy Studies, University of Calif. San Francisco.

[19] State of California, Birth Cohort File 1981, Table 81P-202A.

[20] U.S. Dept. of Health, Education and Welfare, supra.

[21] Dott, A.B., and Fort, A.T., "The Effect of Availability and Utilization of Prenatal Care and Hospital Services on Infant Mortality Rates", 123 AM.J. OB GYN, 854-860 (Dec. 15, 1975).

[22] Garfinkel, J., et al., "Infant Maternal and Childhood in the U.S., 1968-1973" DHEW Pub. No. (HSA) 75-5013, Rockville, Md.

[23] Michigan Dept. of Public Health, "Infant Deaths in Michigan: Analysis and Recommendations" Report (1982).

[24] Paneth, N., "Infant Mortality Reexamined," 247 J.A.M.A. 1027 (Feb. 19, 1982).

[25] U.S. Census Data, 1980.

[26] See exhibits prepared for the Select Committee on Hunger.

[27] "Tax Cut Failed to Help Female Breadwinner", San Francisco Chronicle, July 13, 1984.

[28] See exhibits prepared for the Select Committee on Hunger.

[29] Annual Survey of Health Facilities, Modern Healthcare, May 15, 1984.

[30] Riordan, "The Wards Are Paved with Gold" Washington Monthly, February 1983.

[31] Children's Defense Fund, a Children's Defense Budget: An Analysis of the President's Fiscal Year 1984 Budget and Children (2d Ed. 1983).

C. Maternal malnutrition is a leading cause of LBW and IM

The health of an infant at birth reflects the nutritional status of the mother before and during pregnancy. Recently, the role of adequate maternal nutrition has undergone considerable scrutiny. Many health experts now concur that the quality and quantity of food consumed during pregnancy is critically important, particularly for low-income women who have few resources and possibly a lifetime of poor nutrition.[32]

Infant birthweight is significantly affected by the mother's weight before pregnancy and weight gained during pregnancy.[33] Fully one-third of LBW in the U.S. is believed to result from retarded fetal growth during pregnancy.[34] Poor nutrition accounts for at least 57 percent of LBW in Black newborns.[35]

Severe deprivation of certain specific nutrients in early pregnancy leads to an increase in congenital abnormalities. Lesser nutrient deprivation later in pregnancy apparently results in smaller infants, decreased gestation time, and associated increases in infant mortality.[36]

The implications of LBW are staggering. An analysis of individuals in the U.S. with long-term disabilities originating prior to age 18 revealed that in 75 percent of the cases, the defect had its origin before birth. 94 percent of these disabilities were neurological;[37] these include discrepancies in brain size and structure, brain cell number, and brain cell function. The resulting developmental problems include abnormalities in spontaneous behavior, responses to various stimuli, and learning ability. In general, the more prolonged and severe the deprivation, the more profound and irreversible have been the abnormalities noted.[38]

The relationship between these factors is clear: malnutrition is a major cause of LBW. LBW is the cause of the greatest number of deaths in the first year of life and is the major cause of disability in childhood.[39]

D. The solutions to LBW are known and cost effective

As mentioned earlier, the major cause for these high LBW rates are poor nutrition and lack of comprehensive prenatal care. The solutions are known. It doesn't take more technology, it doesn't take more doctors. It doesn't even take more money. Comprehensive prenatal care, including adequate nutrition counseling, and adequate food subsidies are indisputedly the solution and are cost effective.

Reports estimate savings in expensive hospital technology due to healthier births at rates ranging from $1.70 to $3.00 for each dollar spent in prenatal care.[40] A study of the MediCal funded California Obstetrics Access Project found that for every dollar spent on good prenatal care, $2,00 were saved in reduced need for expensive hospital resources and care.[41] For example, the extensive cost effectiveness study included in the Public Advocates Infant Mortality Petition showed that the current cost of providing neonatal intensive care and first year rehospitalization for LBW infants is $638,364,300. The expected cost of providing such care with the reduced incidence of low birthweight resulting from comprehensive prenatal care coverage, would be $90,199,040. This is obviously a tremendous savings, $548,165,260, ($638,364,300 $90-199, 040). After subtracting the costs of providing comprehensive prenatal care, $187,084,040, the resultant real dollar savings to the federal government is $361,081,220.

The above estimates for both NICU and rehospitalization include only Medicaid costs. Other federal programs which pay for both intensive care and rehospitalization include the Crippled Children's Program and the MCH Program. The MCH

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[32] Higgins, A.C. "Nutritional Status and the Outcome of Pregnancy," 37 J. Can. Dietetic Assn. 17 (1976).

[33] Kennedy, E.T., et al., "Effect of WIC Supplemental Feeding on Birth Weight," 80 J. Am. Dietetic Assn. 220 (1982).

[34] Siever, O'Connell, "Montreal Diet Dispensary," Urban Health (Mar. 1979)

[35] Hemminki, E., Starfield, B., "Prevention of Low Birth Weight and Pre-Term Birth," 56 Milbank Memorial Fund Quarterly/Health and Society 339–361 (1978).

[36] Margen, S., "Studies of Maternal Nutrition and Infant Outcome: Statistical Versus Biological Significance", Birth, Vol. 9:3 (Fall, 1982).

[37] Higgins, A., supra.

[38] Osofsky, H., "Relationships between prenatal medical and nutritional measures, pregnancy outcome, and early infant development in an urban porverty setting", Am. J. Ob. Gyn. (Dec. 1, 1975).

[39] U.S. Dept. of HHS, "Better Health for our Children: A National Strategy" (Report of the Select Panel for the Promotion of Child Health to the U.S. Congress and Secretary of Health and Human Services, 1981).

[40] Johnston, P., supra

[41] Korenbrot, C. supra.

Program alone provided a total of $7 million, or 11 percent of its total budget, for neonatal intensive care in 1978.[42] Finally, the federal dollar figure does not include long-term costs, such as treatment and institutionalization for physical and mental disabilities not requiring hospitalization, that are more frequently associated with low birthweight.[43]

1. Women, Infants, and Children Program (WIC).—Recent U.S. studies show that babies being born to women who participate in WIC are 90-110 grams heavier. The more important finding, however, is that fewer LBW babies are born to WIC participants. In a study contrasting this finding with the incidence of LBW in women who had not participated in WIC, it was concluded that every dollar spent on WIC saved $3 in medical care costs.[44] A study in Missouri which looked at just Medicaid cost savings attributable to WIC found a 1:1.42 ratio, in favor of WIC.[45] In Massachusetts, the neonatal mortality rate for WIC births was one-third that of comparable non-WIC births: it costs $35 per month to provide a complete nutrition package for an infant; it costs about $1,400 per week to hospitalize an infant for malnutrition.[46] These reports of savings are all conservative since none take into account the long term costs associated with treatment and education of LBW babies who developed physical and mental disabilities.[47]

There is an ethical and moral imperative to limit the incidence of LBW and resulting IM caused by poor nutrition. But in addition to the ethical questions, it is both agreed and cost effective to prevent LBW rather than to try to treat its results.

2. Inadequate Funding for WIC.—Despite the effectiveness of WIC in improving maternal and child nutrition, it is estimated that the California WIC program serves only 23 percent of those eligible. This means that 740,844 poor women, infants and children are not participating in a vital nutrition program for which they are eligible. San Francisco currently serves only 30.6 percent of those eligible.[48] These figures are estimates, based on census data, because the federal government has dropped the requirement that waiting lists must be reported. Perhaps the Reagan Administration feels that what they don't know can only hurt someone else.

The figures for those being served are deceiving in another way as well. Because of cutbacks, the state has been forced to choose who among the eligible population will receive services. For example, poor children up to 5 years of age are eligible for WIC services. Yet in Alameda Country, children are routinely dropped from the roles after 18 months unless there is a serious health problem. Women who are not breastfeeding are dropped after 6 weeks, even though federal regulations specify they're eligible for six months.

II. INFANT MALNUTRITION

In addition to maternal health and its impact on birth outcome, there is also the problem of infant nutrition. Given the poverty of the high risk population, one might think that the less expensive option of breastfeeding would predominate. In fact, in 1950, Black women did breastfeed significantly more than white women (73 percent v. 56 percent). By 1976, however, only 20 percent of all black mothers breastfed v. 41 percent of white mothers.

A. Breastfed babies are healthier

There is a major difference in the health of babies who are breastfed vs. those who are bottle fed. Mother's milk has immunological and nutritional properties that infant formula does not approximate. There is wide scientific agreement that breast feeding affords dramatic protection against many serious diseases of infancy. Without this transitional protection in the first months of life, the infant is dangerously vulnerable.

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[42] U.S. General Accounting Office, Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome (Report to U.S. Congress, Jan. 21, 1980)

[43] 129 Cong. Rec. (Sen. Cranston) (daily ed. Jan 26, 1983).

[44] Statement of Eileen Kennedy, Int'l Food Policy Research Institute, Hearing Before the Select Committee on Children, Youth, and Families, U.S. House of Representatives (June 30, 1983).

[45] id.

[46] 112 Cong. Rec. (Sen. Hollings) (daily ed. Jan 24, 1984).

[47] Kennedy, E., supra

[48] See exhibits prepared for the Select Committee on Hunger.

B. Bottle feeding can be hazardous to a baby's health

Mortality and morbidity studies reveal that bottle feeding increases infant disease and hospitalization. There are numerous health hazards associated with the use and misuse of infant formula. Formula deficiencies have caused convulsions, megaloblastic anemia, goiter, prolonged prothrombin time, gastrointestinal complications and inability to gain weight.

Improper preparation and storage causes kidney disease, gastroenteritis, bacterial infections, anemia malnutrition, increased susceptibility to other diseases, and milk allergies.

Finally, bottle feeding costs more. In 1981 it was estimated if breastfeeding were widely adopted, the savings in hospitalization, emergency room, outpatient services, and extra expense of formula would total nearly $400,000,000 per year.

III. WHAT NEEDS TO BE DONE

As discussed earlier, comprehensive prenatal care available to all young women in need and access to nutritious diets would greatly reduce the problems of low birth weight, infant mortality and child malnutrition. With commitment and some policy and administrative rule changes this important access could be available.

A. Prenatal care

The passage of the Child Health Assurance Program now extends health services, including prenatal care, to many women and children who were previously ineligible. There is need, however, to assure that these services are adequate and fully utilized. National leadership is required to establish a uniform definition of comprehensive prenatal care and to require states to provide this care to its high risk poor populations. The U.S. Department of Health and Human Services should require states to provide assurances that the prenatal care provided through Medicaid and the Maternal and Child Health Program includes not only specified periodic visits and routine laboratory tests, but also other important care including:

Screening and counseling regarding nutrition, and substance abuse;

Education on topics, including but not limited to breastfeeding, proper infant formula use, use of medication, infant care and parenting.

B. Nutrition

Clearly, federal support for WIC must improve. Furthermore, Congress must use its authority to improve the content of the WIC program by requiring promotion of breast feeding, including education on breastfeeding for those requesting infant formula coupons, unbiased educational materials emphasizing the superiority of breastfeeding, an on-site lactation counselor to ensure that the regulations encouraging breastfeeding are enforced, proper instruction in the preparation of formula, and the proper categorization and assistance for those women choosing to supplement their breastfeeding with formula feeding.

Additionally, the FDA has written in draft form new label regulations for infant formula. These regulations should have been finalied some time ago. Congress can use its authority to encourage the FDA to finalize adequate labeling regulations which require among other things that infant formula cans carry pictorial labels which will convey the procedures for safe use to all—even those who do not read English.

Further, hospitals receiving federal money should be required to promote breastfeeding by the disbursement of unbiased education materials. Lactation counselors should be on the staff of these hospitals to provide support to breastfeeding mothers and proper instruction in formula use.

C. Educational campaign

The only way to assure adequate access to these vital services is through a major education campaign. Understaffed programs cannot be expected to conduct the kind of outreach necessary to bring in the eligible population. Government must use all its resources to reach out to this population to ensure the effectiveness of WIC, Medicaid and other vital programs. Effective use of the mass media, including radio, TV and billboards, is the best way to reach such a large and dispersed population. Sometimes the biggest obstacle to health care and nutrition is simple lack of information.

D. Expand view of hunger and its causes

Earlier in this discussion there was mention of the unavailability of food stores as a contributor to malnutrition. Public Advocates has invested tremendous firm resources into representing this issue and working with community organizations and state government to fashion solutions. Think for a moment of the impact on nutrition when all shopping must be done at expensive convenience stores. Potato chips, sodas, and candies are likely to be in much greater supply than fresh fruits and vegetables.

Traveling to a less expensive store providing greater variety is likely to be expensive (taxi) or very inconvenient (taking a bus with grocery bags). This problem is clearly not as disabling as having no money to buy any food, but it contributes to the problem of hunger nonetheless.

The problems discussed above can be solved through more cooperative markets in the inner city, incentive programs to keep more food chains in low-income communities, and special support for minority grocery ventures. Also, farmers' markets are an excellent way to bring fresh food to the inner city while perhaps adding vitality to a once vacant lot.

The presence of nutritious food in the community is key to an effective educational program that reaches children who will grow up to be pregnant women and parents. This one problem is offered merely as an example of the need for creativity and vision in attacking hunger.

Thank you.

AN ADMINISTRATIVE PETITION TO
THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES

BLACK WOMEN'S HEALTH PROJECT/NATIONAL WOMEN'S HEALTH NETWORK;
COALITION FOR THE MEDICAL RIGHTS OF WOMEN;
COALITION TO FIGHT INFANT MORTALITY;
FAMILY PLANNING FORUM;
FOOD RESEARCH ACTION CENTER;
LEAGUE OF UNITED LATIN AMERICAN CITIZENS;
MEXICAN-AMERICAN LEGAL DEFENSE AND EDUCATIONAL FUND;
NAACP-Western Region;
NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE;
NATIONAL COUNCIL OF NEGRO WOMEN;
NATIONAL URBAN LEAGUE;
NATIONAL WOMEN'S HEALTH NETWORK; and
N.O.W. LEGAL DEFENSE AND EDUCATIONAL FUND,

Petitioners,

vs.

SECRETARY OF HEALTH AND HUMAN SERVICES, Margaret Heckler,

Respondent.

ADMINISTRATIVE PETITION TO REDUCE THE INCIDENCE OF LOW BIRTH WEIGHT AND RESULTANT INFANT MORTALITY

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APPENDIX [Cities Surveyed by Public Advocates]

I. INTRODUCTION

There is an infant death gap in this country, and it is widening. For years, Black babies have died before their first birthday at a rate that has far exceeded that of white infants.

This infant death gap has been an expected--and in many ways accepted--statistic due to its consistency over the years. In 1950, the Black infant death rate (43.9 per 1,000 live births) was 61% higher than the white rate (26.8 per 1,000 live births). By 1979, the Black rate (21.8) was _91% higher_ than the white rate (11.4).

While there has been improvement in the overall infant mortality rate and while white infant mortality has reached a level that some in the nation are satisfied with, the infant death rate for major sectors of society remains deplorable. Moreover, the infant mortality rates among Blacks in major cities throughout the United States in 1981 (the last year for which data are available for most cities) were equal to and in some instances higher than the infant mortality rate of whites in 1950.

Although overall infant death rates (white and nonwhite combined) dropped from 26.0 in 1960 to 13.1 in 1979, very little change has occurred in the percent of very small babies born, the major factor contributing to infant deaths. In fact, Blacks in America, a so-called "developed" country, have such high rates of underweight babies that they have been used as a comparison group to populations in "developing" areas such as Argentina, Cuba, and Tanzania. In other words, nonwhites in America, one of the most affluent countries in in the world, exhibit the low birthweight patterns of residents of Third World countries.

In fact, national statistics demonstrate that there has been little change in the past 10 years in the percentage of infants who are born of low birth weight (that is, less than five 1/2 pounds). In 1972, the Black low birth weight rate was 13.3% of all Black live births; by 1980, the national Black rate was 12.5%. In major cities in the U.S., the rate was 13.08% in 1981. These trends confirm the widely held observation that the overall decrease in infant mortality in this country reflects improved medical care for high risk infants and not any significant decrease in the number of high risk infants born.

Small infants are not only at greatest risk of dying but, for those infants that live, and today the majority do, the mental and physical disabilities which they suffer and the expense of caring for them take an immeasurable toll on families, society, and the nation as a whole.

Civil rights, women's, children's, and health organizations have joined together in this Petition to ask the Reagan Administration to take those steps necessary to prevent low birth weight and resulting infant mortality. The organizations are deeply concerned that if action is not taken now, Black and other low income communities will be condemned to years of suffering from preventable infant deaths and morbidity.

This Administrative Petition not only proposes remedies to the problem, but provides new data from a survey undertaken by Public Advocates in conjunction with the University of California at Berkeley School of Public Health to determine the current status of maternal and infant health. Additionally, this Petition highlights the results of programs that have proven successful in increasing birth weight and lowering infant mortality. A cost effectiveness analysis of providing comprehensive prenatal care to those in need is also included.

The Public Advocates Survey is discussed in depth in Section IV. The most disturbing results are that infant mortality among Blacks is going up in a majority of the 45 cities surveyed and the low birth weight rates among Blacks have remained virtually unchanged. Further, the gap between white and Black infant death and low birth weight rates has dramatically widened.

Additionally, the Survey revealed that for those factors that contribute to low birth weight and infant mortality, the outlook is not good. Between 1978 to 1981, Blacks went from a teenage pregnancy rate 107% higher than whites to 118% higher. Regarding prenatal care, the Public Advocates Survey found that the percentages of Black and white women getting prenatal care in the first trimester had gone down while the percentages of women receiving no prenatal care had gone up.

There is no mystery concerning what is needed to increase birth weights and reduce infant mortality. For years the medical literature has been replete with references to the fact that early comprehensive prenatal care does increase birth weight and does decrease infant mortality. The programs reviewed in this document in Section V, further substantiate this premise. Not only is this information readily available in the medical literature, but the federal government has initiated several studies which have further documented that low birth weight is a serious public health problem in the United States and that identification of high-risk populations and the provision of comprehensive prenatal care to those groups can drastically reduce these appalling low birth weight and infant mortality rates. See Section VII.

Petitioning organizations reluctantly have included a cost effectiveness analysis which demonstrates conclusively that it would be cost effective for the federal government to embark on a national program to provide comprehensive prenatal care to low income women in need of this care. The reluctance to include the cost effectiveness analysis was not because there was any doubt that comprehensive prenatal care would prevent low birth weight and reduce the expenses that are necessarily involved in caring for those infants; but rather petitioners are so aware of the moral obligation to provide this most basic health care, that there should be no need to persuade the government that the provision of this care is cost effective. Cost effectiveness in this context seems callous and unnecessary.

Petitioners' analysis shows that the federal government can save $361,081,220 by providing comprehensive prenatal care to all low income women. See Cost Effectiveness, Section VI.

This cost savings figure was computed as follows: It currently costs the federal government $638,364,300 to pay for neonatal intensive care (NICU) and rehospitalization for low birth weight infants during the first year of life. This figure could be reduced to only $90,199,040 if comprehensive prenatal care were available to all low income women. The additional expense of providing such comprehensive prenatal care is $187,084,040. By subtracting the costs of the additional coverage ($187,084,040) from the projected savings of $548,165,260, a final cost savings figure of $361,081,220 is obtained.

Current federal cost for NICU and rehospitalization	$638,364,300
Federal cost after providing comprehensive prenatal care	- 90,199,040
	$548,165,260
Federal cost for providing comprehensive prenatal care	-187,084,040
Savings to federal government	$361,081,220

In general, America's low international ranking in terms of infant mortality is an embarrassment. A country with the wealth of the United States and the technological know-how should be at the top of the list of such a sensitive indicator of a nation's health. Actually, statistics indicate that the United States saves small babies on a par with any country in the world; the infant mortality rate in the U.S. remains high because there are so many small babies to save.

Recently, (May 24, 1983) the Wall Street Journal published an article describing how Sri Lanki had significantly reduced its infant mortality rate. Their efforts were described as a real success story for the Third World. The article discussed the reality that a country's infant mortality rate measures more than infant deaths but it is also a measure of "food and water supplies, political upheaval, and the quality of housing, schools, and health care." The writer went on state that the infant mortality rate also "measures. . . the attitude of the government." A Sri Lanka economist was quoted as saying that a high infant mortality rate "shows that the ruling elite aren't interested... It shows a high degree of irresponsibility." Similarly, something can be done about low birth weight and infant mortality rates in the U.S. Petitioners urge the Reagan Administration to take the responsible course and do something about it now.

In Section VIII, Petitioners put forward specific rulemaking changes that can be implemented by Health and Human Services, which will coordinate existing federal programs aimed at maternal and infant care; develop an educational campaign that will inform women of the importance of prenatal care and make the need for prenatal care as well known to low income Americans as the Smokey the Bear campaign phrase, "Only you can prevent forest fires," is now known in every American home; encourage states to expand their Title V and Medicaid programs so that they can efficiently provide comprehensive prenatal care to all financially needy families, and begin to control the appalling problem of teenage pregnancy in America by providing pregnancy prevention information and prenatal care to high-risk teenagers if they become pregnant.

These solutions are interim steps. Legislative changes are clearly needed to permanently institutionalize this country's commitment to maternal and infant care. The rulemaking changes proposed in this Petition, however, are important interim steps and will help prevent low birth weight and infant mortality.

Footnotes in this document are cross-referenced to the bibliography, where each reference has been assigned a number. Where a colon separates two numbers, the first number represents the document and the second number indicates the page. Where a semi-colon separates two numbers, it indicates more than one cite within the footnote.

II. PETITIONERS

This Petition is being filed on behalf of civil rights, women's, health and children's organizations that are concerned about the widening infant mortality gap between whites and nonwhites in the United States. These organizations are also deeply concerned that the failure to address adequately the underlying causes of infant mortality means that the gap will continue to widen until comprehensive prenatal care is available to all who need it.

A. Civil Rights Organizations

The National Urban League, the NAACP-Western Region, Mexican-American Legal Defense and Educational Fund, and the League of United Latin American Citizens are well known civil rights organizations with constituencies that range into the hundreds of thousands. These organizations believe that access to adequate health care is a fundamental civil right and that healthy pregnant women and babies are the cornerstone of a vital society.

B. Health Groups

The Black Women's Health Project (NWHN), National Women's Health Network, the Coalition for the Medical Rights of Women, the Coalition to Fight Infant Mortality, the Food Research Action Center and the Family Planning Forum focus on the particular health and nutrition needs of low income women and minorities. Each of these organizations devotes its resources to educating the public and encouraging policies that will make adequate health care available to all low income and minority citizens. These groups are gravely concerned that the high infant mortality rates in low income, minority communities persist when these rates could be reduced if health resources were properly directed to the populations most at risk.

C. Women's Organizations

The National Organization for Women Legal Defense and Educational Fund and the National Council of Negro Women recognize women's needs for adequate health care as well as their need for opportunities in education, employment and personal advancement. Of key concern is that pregnant women have the necessary resources and support to bring healthy, potentially productive babies into the world. This cannot be accomplished if the low income and minority women in this country are denied access to the quality of health care that is available to middle and upper income women.

D. Children's Organizations

The National Black Child Development Institute is a non-profit membership organization with affiliates in 32 cities which plays an advocacy role for all Black children. It has focused on such issues as adoptions, foster care, and education.

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III. JURISDICTION AND RESPONDENTS

The cabinet and sub-cabinet members of the Department of Health and Human Services have the authority and power to promote policies, programs and practices which will reduce infant mortality among the nation's high-risk populations.

Respondent Secretary of Health and Human Services (DHHS)

Secretary Heckler is vested with the authority to guide the nation's health policies and the power to implement existing federal health legislation, 42 U.S.C. § 3501. Specifically, the Secretary is entitled to receive reasonable assurances that certain conditions will be met prior to the disbursement of federal grants for health care pursuant to the Maternal and Child Health Program (Title V of the Social Security Act, 42 U.S.C. § 701, et seq.), the Adolescent Pregnancy Programs (Title VI of the 1978 Amendments to the Public Health Service Act, 42 U.S.C. § 300 et seq.), the Comprehensive Public Health Service Grants Program (42 U.S.C. § 246), Migrant Health Centers and Services Grant Program (42 U.S.C. § 254b), Community Health Centers (42 U.S.C. § 254c), the Family Planning Services and Population Research Act (Title X of the Public Health Service Act 42 U.S.C. § 300), and the Social Services Block Grant Title XX (42 U.S.C. § 1397a(a)(2)(A)).

Further, under the Social Security Act, which encompasses both the Maternal and Child Health Program and Medicaid, the Secretary is given broad authority to mandate "such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which (s/he) is charged under this chapter." 42 U.S.C. § 1302. The Medicaid program specifically provides in pertinent part that: "A state plan for medical assistance must provide such methods of administration. . . as are found by the Secretary to be necessary for the proper and efficient operation of the plan." 42 U.S.C. § 1396a(a)(4).

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IV. EVERY SIGNIFICANT INDICATOR REVEALS A WIDENING GAP BETWEEN THE SURVIVAL PROSPECTS OF BLACK AND WHITE INFANTS

The overall infant mortality rate is a crude, imprecise measure of a nation's health. Recently, increases in the overall rate in 11 states have touched off heated exchanges between government critics and bureaucrats about who is responsible.[1] The death of American babies is an issue that deserves open and pointed debate; while the debate rages, however, babies are dying needlessly.

Hidden under the overall infant mortality statistics are truly shocking figures that no one--including government officials--disputes: in America today, a Black baby is almost twice as likely as a white baby to die before his or her first birthday.[2]

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[1] 107:7

[2] 11:7

The following is an in depth discussion of infant mortality in the United States which both compares this country's ranking with other countries and examines infant mortality among various groups within the U.S. This section also reports the methodology and results of a survey conducted by Public Advocates. This survey was undertaken because of the lack of current data regarding infant mortality rates by race. The Public Advocates survey was conducted in conjunction with the University of California at Berkeley School of Public Health.

A. Public Advocates' Survey

1. Lack of Current Data

The last year for which final state and national infant mortality statistics are available from the National Center for Health Statistics (NCHS) is 1979.[1]* Currently, there is almost a three-year lag between the end of a calendar year and the date on which final statistics for that year are released to the public by NCHS. Provisional statistics (based on a 10%

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[1] 102:24

* On June 30, 1983, one day after this Petition was filed, Dr. Edward Brandt, Assistant Secretary for Health, and attorneys for petitioners both testified before Congress' Select Committee on Youth, Families and Children. Dr. Brandt made public for the first time the final 1980 statistics, which were an overall IMR of 12.6, a Black IMR of 21.4, and a white IMR of 11.0.

sample of the population) are available for 1980, 1981, and 1982 but racial breakdowns for infant deaths have not yet been published for these years.

Breakdowns of city data needed for analysis in this petition have not been available from the federal government or government-sponsored sources since 1978.[1]

Public Advocates reviewed the state and national statistics from NCHS, including provisional data for 1980-1982 and natality data for 1980, but also conducted an additional survey to collect more recent data for selected cities throughout the country.

2. Methodology

During the first half of 1983, Public Advocates conducted a telephone survey and collected data on infant mortality broken down by ethnicity or race from 45 cities. These cities varied in their racial, ethnic and socio-economic makeup: 30 cities had populations of 250,000 or more, 15 had populations below 250,000. Geographically, 7 cities were located in the East and Northeast, 12 in the Midwest, 13 in the South and Southeast and 13 in the West. Where city data was not available, county statistics were used.

Most of the cities were randomly chosen. A few cities, however, were selected for study because community groups alerted

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1. 114

Public Advocates to their high rates of infant mortality; other cities were selected because the media had already focused attention on their high rates of infant deaths.

For the 45 cities information was requested from vital statistics divisions of city, county and state health departments for the years 1978 through 1982 for the following categories: overall infant mortality rate (IMR),[a] IMR by area of city, stillbirths,[b] neonatal deaths,[c] post-neonatal death rate,[d] low birthweight,[e] prematurity,[f] teenage pregnancies, and prenatal care. Breakdowns by race were requested for each category. All data collected was for city residents.

Inconsistencies in recordkeeping and lack of data collection by race in the cities' vital statistics units prevented Public Advocates from obtaining data for every category from each city. Few cities had compiled data for 1982. Infant mortality and low birth weight statistics were most consistently available. Small samples were obtained for very low birth weight births, births to teenagers, and prenatal care. Also a few cities reported nonwhite rates rather than Black rates. In the Public Advocates Survey (hereinafter sometimes referred to as P.A. Survey) Black and nonwhite were combined. Most references to the PA survey will refer to those rates as Black.

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a. infant deaths per 1,000 live births
b. fetal deaths, excluding abortions
c. deaths to infants under 28 days old
d. deaths to infants 28 days to one year old
e. less than 5 1/2 pounds (2,500 grams) at birth
f. born before 38 weeks' gestation

The data were subsequently processed and analyzed by Consultants from the School of Public Health, University of California, Berkeley.

The findings of the Public Advocates Survey appear throughout this petition.

B. Infant Mortality Rate (IMR) - Components and Significance

The infant mortality rate (IMR) is the number of infant deaths up to one year of age, per 1,000 live births. For example, if a country had 3,000 live births in a given year and 33 infants under age one died in the same year, that country's IMR would be 11.0 (33 divided by 3,000, multiplied by 1,000).[1]

IMRs can be based on linked data (where birth and death records are matched for each individual infant) or on unlinked data (all births and deaths occurring in a calendar year). Most of the statistics in this petition are based on unlinked data. Linking is not routinely done in the United States, except for a few states and cities.[2]

Although crude IMRs can provide some clues to the status of a nation's health, especially the health of mothers and babies, the statistics which comprise overall IMRs--i.e., death rates before and after the first 28 days of life--are often more sensitive measures of national health and of specific remedial and preventive techniques which affect that health.

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[1] 75:1

[2] 83:15-16; 115

Similarly, more insight can be gained by comparing IMRs for various subpopulations: whites to nonwhites, babies whose mothers had prenatal care to those who did not, teenage mothers to older mothers, pregnant women above the poverty level to those below it, and babies who are born underweight to those of normal weight.

In reviewing the professional literature, as well as in its own survey, Public Advocates focused on data that would shed light on this complex interaction among these factors and how they affect crude, overall IMRs.

1. Neonatal Mortality (deaths occurring within the first 28 days of life)

There is an especially strong link between high neonatal deaths and babies born underweight (or low birthweight). The neonatal death rates for babies who weigh 1,000 grams or less is 750 per 1,000 births, as compared to only two deaths per thousand for babies who weigh between 3,000-3,500 grams.[1]

Fifty years ago, a little more than half of infant deaths in America occurred in the neonatal period,[2] the first 27 days of life. Now, three-fourths of all infant deaths occur in the neonatal period.[3] This shift does not mean that more babies are dying now than in previous years. Fewer are dying. The percentage of deaths in early infancy is rising because of advances in the past half-century in controlling the factors -- _e.g._, poor sanitation, infection -- which killed babies later in infancy.[1]

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[1] 147:829
[2] 147:829
[3] 50

Neonatal deaths are closely linked to inadequate prenatal care, delivery procedures, and medical care of the newborn.[2] The neonatal period is also the time when intrauterine factors, such as retarded fetal growth, have their greatest effect.[3]

Race is also a factor. In 1979, the Black neonatal death rate was 80% higher than the white rate.[4]

2. _Post-Neonatal Mortality (deaths occurring from 28 days up to one year)_

Post-neonatal deaths account for only one-fourth of infant deaths in the United States.[5]

Environmental, social, and economic factors, _e.g._, poverty, are more likely to affect infants after the first month of life.[6] Much of post-neonatal mortality is not related to, nor influenced by, prenatal care.[7] Further, there is disturbing evidence that in some cases, medical science is prolonging the lives of tiny infants who are born critically ill and do not survive. In the U.S. between 1970-1978, the numbers of infant deaths related to respiratory disease, one of the three major complications of low birthweight that often leads to death, decreased

1. 50:3
2. 104:8
3. 125:366
4. 104:8
5. 50:4
6. 104:8
7. 55:6

overall by 31% but increased 444% in the postneonatal period.[1]

In 1979, the last year for which final national data are available, the Black post-neonatal death rate was more than twice the white rate.[2]

3. Fetal Mortality - Stillbirths

Fetal deaths (stillbirths) include deaths of fetuses of 20 or more weeks' gestation, excluding abortions.

Historically, nonwhite fetal death rates have been higher than the white rate. In 1950, the nonwhite fetal mortality rate* (FMR) was 24.8; the white FMR was 13.3. ("Nonwhite" includes Blacks; fetal death rates for Blacks-only were not available until 1979.) By 1970, the white rate was down to 8.6, while the nonwhite rate was 13.9. The gap between white and nonwhite fetal deaths rates had narrowed by 1979 (5.9 for whites and 8.4 for nonwhites). Unfortunately, the newly available 1979 rate for Blacks-only was 9.0 higher than the nonwhite rate, and white rates. Provisional 1980 fetal mortality rates by race are not yet available from NCHS.[3] Some cities include fetal deaths when reporting infant mortality rates, but in the Public Advocates Survey, all fetal deaths were excluded.

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1. 27:70
2. 104:8
3. 104:54

* Fetal mortality rates (FMRs) are the number of fetal deaths divided by the total live births plus fetal deaths, multiplied by 1,000.

4. International Comparisons of Infant Mortality

The overall infant mortality rate, although a crude measure by American standards, is nonetheless useful in international comparisons. For the past 17 years, the U.S. has maintained the unimpressive rank of between 14th and 18th of 25 industrialized nations with the lowest infant mortality rates.[1] For many years, the U.S. infant death rate has exceeded Sweden's by more than 75%.[2] In 1974, when the U.S. rate was 16.7, Sweden's was 9.2.[3]

In 1978, America's infant death rate (13.8) was higher than the IMRs for fifteen other nations, not an enviable record for a country with a high standard of living. In the past 50 years, the infant death rate for Finland and Japan declined more than 90%, while the U.S. rate dropped only 80%.[4]

America's international ranking fell from sixteenth in 1978 to eighteenth in 1979. Among the countries with lower infant death rates than the U.S. were: Sweden (7.3), Canada (10.9), Hong Kong (12.3), Australia (11.4), and West Germany (12.9). The U.S. ranked only six countries above Czechoslovakia (17.7).[5]

In 1980, the U.S. was still ranked eighteenth worldwide, with an infant death rate of 12.5 per 1,000 live births.

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[1] 64:986
[2] 64:986
[3] 146:213
[4] 147:832
[5] 147:761

America's IMR was barely better than East Germany's (12.6), and was worse than seventeen other countries, including Sweden (6.9), Japan (7.5), Finland (7.6), Spain (11.1), Hong Kong (11.2) and Ireland (11.2).[1]

To appreciate the lifesaving impact of an infant death rate which is approximately five points lower consider the following: If the U.S. infant death rate in 1977, which was 14.1, had been equal to Japan's (8.9), 17,000 fewer American babies would have died that year.[2]

Despite the historical and present lag, the most optimistic goal thus far proposed by the U.S. Department of Health and Human Services is to lower the national infant death rate to no more than 9.0 per thousand (slightly higher than Japan's 1977 rate) by 1990. The more conservative 1990 goal for Blacks, Hispanics, American Indians, and other ethnic subgroups (12.0 deaths per thousand live births) institutionalizes rather than eliminates the current racial death gap.[3]

Countries with lower rates of infant mortality than the United States use comprehensive preventive programs which stress adequate and accessible prenatal care, sex education for teenagers, good nutrition, screening for high-risk pregnancies, high quality obstetric care, and follow-up home visits, plus other basic preventive services.[4] These services have yet to become the right of every mother and baby in the United States, making even the modest 1990 goals seem impossible to reach.

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[1] 148:842
[2] 147:842
[3] 139:17
[4] 146:217; 64:985; 128:28

5. U.S. Infant Mortality Rates by Race

> "Higher mortality among black infants has been observed ever since reliable statistics have been available. Furthermore, the gap is not narrowing..."
>
> Joel C. Kleinman, Ph.D.
> Samuel S. Kessel, M.D.
> National Center for Health Statistics[1]

Between 1915 and 1950, there was a steady decline in the U.S. infant death rate, largely due to better sanitation, decreases in infectious diseases, family planning, improved nutrition, and better access to health care.[2]

As shown in Table A, by 1950, the U.S. infant mortality rate for whites was 26.8 deaths per 1,000 live births. Black American infants, however, died at a rate 64% higher (43.9 deaths per 1,000 live births). Twenty years later, in 1970, the white IMR was down to 17.8, while the Black IMR (32.6) was 83% higher than the white rate. In 1979, the last year for which racial breakdowns are available from the National Center for Health Statistics, the white rate reached an all-time low of 11.4. Again, the Black rate, consistent with this deplorable statistical pattern, was 91% higher (21.8).[3] The gap is indeed widening.

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1. 76:29
2. 50:3
3. 104:54

TABLE A

U.S. Infant Mortality Rates, 1950-1981 (selected years), By Race (per 1,000 Live Births)

Year	U.S. Overall	White IMR	Black IMR
1950*	29.2	26.8	43.9
1970	20.0	17.8	32.6
1975	16.1	14.2	26.6
1978	13.8	12.0	23.1
1979	13.1	11.4	21.8
1980	12.5**	***	***
1981	11.7**	***	***

Sources: National Center for Health Statistics, "NCHS Monthly Vital Statistics Report," V. 30, N.13, 12/20/83. Health U.S., 1982, p. 54.

The provisional 1982 overall U.S. IMR is 11.2 per 1,000 live births, the lowest rate ever recorded in the United States. That is little comfort for Black parents, since "the mortality rate for Black infants remains almost twice as high as that for white infants."[1]

It is difficult to obtain accurate data on infant deaths in the Hispanic community. [2] Statistics are also sparse for other ethnic groups. In Los Angeles County, however, several areas with the highest minority concentrations also have the highest rates of underweight babies, neonatal deaths, and infant deaths.[3] One Los Angeles County health planning area,

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1. 11:7
2. 87
3. 87, see appendix

* Includes nonresidents of U.S.
** Provisional statistics.
*** No racial breakdown available.

where Hispanics make up 58.9% of the population, has the highest percentage of underweight babies and the fifth highest infant death rate in the County.[1]

IMRs for American Indians living in the State of California are higher than the IMRs for any other reported group except Blacks.[2]

- Public Advocates Findings - Infant Mortality by Race

The Public Advocates findings from the survey of cities were consistent with though not identical to the national figures from NCHS for the duplicate years studied (1978-79). As in the NCHS report, Public Advocates' Survey revealed an increase in the gap between the white and Black IMRs. The Survey included infant mortality rates by race for 45 cities. The total number of births is in excess of 376,000 for whites and 227,000 for Blacks per year. For those cities in 1978 the white IMR was 12.9 while the Black IMR was 21.9, a rate 70% higher than that for whites. By 1981, the rate for whites had fallen significantly to 11.58 while the Black IMR had decreased only slightly and was actually higher than the 1980 rate. Thus, at the end of 1981, the IMR for Blacks was 82% higher than the IMR for whites.

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1. 88
2. 25:23

TABLE B[*]

Public Advocates Survey of IMR of 45 Cities

Year	White IMR	Black IMR	% Higher for Blacks than Whites
1978	12.86	21.93	70%
1979	12.36	21.27	71%
1980	12.62	20.25	73%
1981	11.58	21.13	82%

Further, the Public Advocates survey revealed that in 32 of the 45 cities, the Black infant mortality rate for 1981 was more than 50% greater than the white rate. Fifteen of those had Black rates that were more than double the white rate.

According to the Public Advocates survey, in 1981, among the larger birth populations, the widest disparities in IMRs between whites and Blacks occurred in the following cities: Jackson, Mississippi; Memphis, Tennessee; Cleveland, Ohio; Washington, D.C.; and Detroit, Michigan. Jackson, for example, showed IMRs of 6.2 and 21.1 for whites and Blacks respectively; these data indicate that the Black IMR was 240% higher than the IMR for whites. See Table C.

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[*] All averages reported in P.A. findings are weighted to eliminate the impact of varying city sizes. A weighted average is computed by using total number of births and total number of outcomes.

TABLE C

Public Advocates Survey of Cities with Number of Black Births Greater than 2,800 in 1981 with Widest Disparities Between White and Black IMRs

CITY	WHITE IMR	BLACK IMR	% HIGHER FOR BLACKS THAN WHITES
Jackson	6.2	21.1	240%
Memphis	7.9	22.6	186%
Cleveland	11.5	31.9	177%
Washington, D.C.	9.5	25.3	166%
Detroit	12.0	26.2	118%

Perhaps the most disturbing evidence indicated by the survey is that infant mortality among Blacks and whites is rising. Between 1980 and 1981 the PA Survey found increases in the Black IMRs in 51% of the cities studied. The white populations in these cities are not immune to the high incidence of infant deaths; increases in white IMRs were found in 37% of the cities studied for those same years.

Probably the rise in white IMRs is influenced by the same factors that are contributing to a rise among Blacks; that is, higher IMRs among people who are low income. A comparison of the national IMR for whites for 1978-79 with the results of the Public Advocates Survey indicates that IMRs for whites in the survey cities were higher than the national average.

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TABLE D

National Comparison of White IMR to Public Advocates Survey for 1978-79

Year	National	Public Advocates Survey
1978	12.0	12.86
1979	11.4	12.36

This may reflect the fact that cities often contain small concentrations of low income whites.

While it may be premature to conclude from these data that the infant mortality rates for poor whites and Blacks are increasing, a pattern in that direction seems to be developing. While more data from 1982 and 1983 is needed to determine whether that trend is in fact occurring, it may fairly be said that a significant problem may be emerging -- one which may be difficlt to combat if not treated immediately.

C. Low Birth Weight, Death, and Disability

> "Low birth weight is the greatest single hazard for infants, increasing their vulnerability to developmental problems and to death." U.S. Surgeon General's report".[1]

There are two reasons for an infant to be of low birth weight (*i.e.*, born weighing less than 5 1/2 pounds or 2,500 grams).

1. It was born too soon (prematurity -- before 38 weeks

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[1] 136:21

gestation), or

2. It was born too small. These are full-term babies who did not grow enough while inside the mother [intrauterine growth retardation (IUGR)]. They are also referred to as "small for gestational age" (SGA).[1]

In either case, low birth weight infants are more likely to die or have serious disabilities than normal birth weight (NBW) babies (5 1/2 pounds or more).[2] In both types of LBW, the lower the birth weight, the more likely the baby will be stillborn or die soon after birth.[3] Low birth weight (LBW) infants are more than 20 times as likely to die within their first year as normal birth weight babies.[4]

Figure 1 illustrates the strong relationship between low birth weight and death, especially in early infancy.

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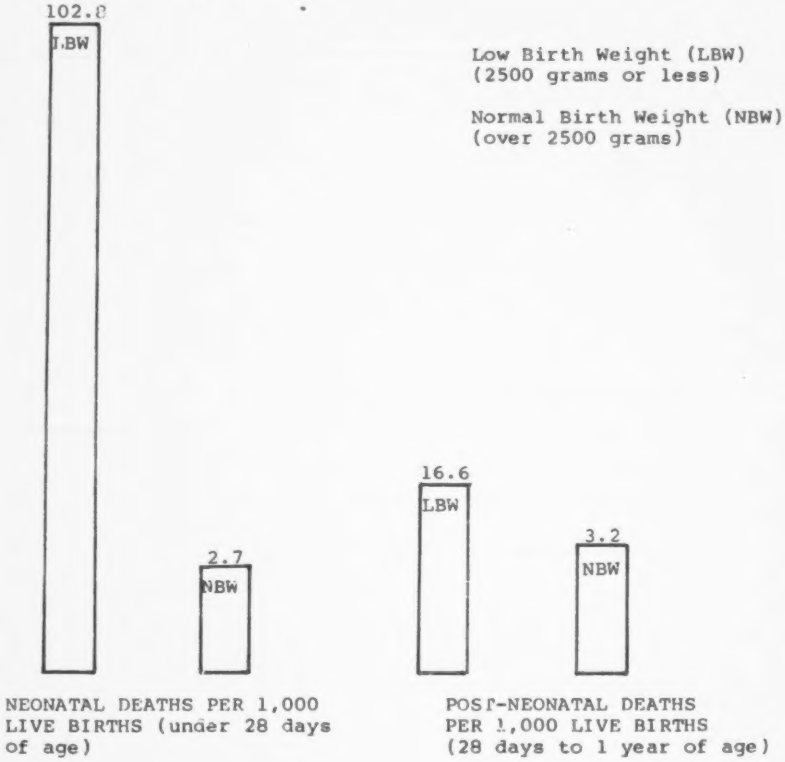
[1] 81:3-4, 50:1
[2] 50:1
[3] 81:3
[4] 136:24

Figure 1

NEONATAL AND POST-NEONATAL DEATHS, ACCORDING TO BIRTHWEIGHT, 1974-75 -- Selected Areas, United States



Source: Shapiro, S., et al., "Relevance of Correlates of Deaths for Significant Morbidity at 1 Year of Age", Am.J. of Obstet. Gynecol., Feb. 1, 1980, p. 365, Table II.

LBW has also been connected with increased occurrence of mental retardation, learning disabilities, birth defects, blindness, autism, cerebral palsy, epilepsy,[1] growth problems, visual and hearing defects, delayed speech, and chronic lung problems.[2]

In the first large-scale study of morbidity by birthweight, which covered eight regions in the U.S., researchers at Johns Hopkins University found that, among infants with birthweights below 1500 grams born in the first half of 1976, the incidence of severe impairment was 14.3 percent.[3] The authors also compared overall problems of low-birthweight infants to those suffered by full-term babies and found that 40 percent of the survivors born under 1500 grams were hospitalized at least once during the first year of life, compared to 8 percent of infants born weighing over 2500 grams.[4]

Continuing physical problems are common in very low birth weight (VLBW) infants -- those weighing under 3 lbs., 5 oz., or 1500 grams. By the time they reach one to three years of age, 20 percent of VLBW infants and 30 percent of those weighing under 2 lbs., 3 oz. (1000 grams) have neurological abnormalities.[5]

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1. 136:24
2. 50:2
3. 113
4. 136
5. 136

1. International Comparison of LBW Rates

International data comparing the U.S. to nine other industrialized nations rank the U.S. second worst in proportion of LBW babies.[1] This high percentage of underweight babies, a percentage which is even higher among America's racial minorities, is one reason for the poor U.S. ranking in infant deaths.[2]

In 1970, only 4.5% of babies born in Sweden (the country with the lowest IMR in the world) were LBW, while 7.8% of U.S. babies were LBW.[3] In 1978, eight years later, the U.S. LBW rate* had only inched down to 7.0%, still far above the Swedish rate.[4]

As an indication of the lifesaving potential of improving LBW percentages, when researchers compared infant and neonatal death rates for each weight category (e.g., 1500-2000 grams, 2000-2500 grams) rather than for all LBW categories combined, they found that babies of the same weight, on the average, had lower death rates in the U.S. than in Norway and Sweden.[5]

This result indicates that the United States saves LBW babies on a par with other countries. What is also obvious is that this country is not as good at preventing low birth weight. America's international rank is not expected to improve until the low birth weight rate is reduced.[1]

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[1] 50:3
[2] 104:8
[3] 146:213
[4] 139:15
[5] 47:990; 61:1232
* The percentage of babies per hundred live births, who weigh less than 5 1/2 pounds at birth.

One observer of the Swedish health care system states that ". . . a compelling case can be made for some solid efforts to emulate the comprehensiveness of Swedish prenatal care and education . . ."[2] Sweden has put a high priority on making sure that its babies are born healthy, one reason for its enviable top world ranking. Swedish mothers are well educated about the value of prenatal care, receive free prenatal care, which includes screening for high-risk patients, and free vitamin and mineral supplements.[3]

As Hein acknowledged, the United States is comparable with Sweden medically, economically, and technologically. "Perhaps it is time for us to find reasonable solutions for our perinatal problems rather than acceptable excuses."[4]

2. Factors which Influence Birthweight

Factors linked to higher risks of low birth weight are: race (not white), age of mother (less than 18 or greater than 35), previous loss of a fetus or infant, short interval between pregnancies, out-of-wedlock birth, no prenatal care,[5] educational attainment of mother (risk decreases as educational status increases), maternal smoking and consumption of alcohol, poor maternal nutrition, poverty,[6] gestational age,[7] and weight gain of the pregnant women.[1]

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[1] 47:990
[2] 110:1028
[3] 146:217
[4] 64:986
[5] 125:367-368
[6] 50:4
[7] 72:7

It is difficult to say that any one of these factors directly causes LBW in babies, and consequently, higher infant death rates. Not every malnourished mother has a low birth weight baby. Not every Black mother has a low birth weight baby. Not every mother who has no prenatal care has a low birth weight baby. But, statistically, where one or more of these factors is present, the likelihood of low birth weight increases.

3. Race and Low Birth Weight

Race is closely associated with low birth weight. A greater proportion of nonwhite infants than white infants weigh less than 5 1/2 pounds at birth.[2] Black infants are about two and one-half times as likely as white infants to be of very low birth weight (under 1500 grams) and two times as likely to be of low birth weight (under 2500 grams).[3] In one classic study of New York births, differences in birthweight accounted for virtually the entire excess of the perinatal death rate of non-whites over that of whites (an excess of 69%).[4]

Nationwide between 1972 and 1974, the Black low birth weight rate (13.3%) was 107% higher than the white LBW rate (6.4%).[5] In 1980 whites gave birth to underweight babies at a rate of

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[1] 72:21
[2] 105:3
[3] 77:12
[4] 7:946
[5] 103:75

5.7. For the same year, the rate for Blacks was 12.5. Thus, the Black low birth weight rate climbed to 119% higher than the white rate.[1]

Figures from the Los Angeles County Health Systems Agency show that planning areas with the highest concentrations of minorities also have the highest LBW rates, neonatal death rates, and infant death rates.[2]

• Public Advocates Findings - Race and Low Birthweight

Public Advocates collected low birth weight data from 32 cities by race for the years 1978-81. Data from 1982-83 would be useful in determining a clear pattern. From the data available, however, it is apparent that there has been no decrease in the incidence of low birth weight particularly among Black infants.

Like the IMR statistics, the data collected in the Public Advocates Survey reveal that the Black low birth weight rate (LBWR) is nearly double the white rate.

TABLE D

Public Advocates Survey of LBWR of 32 Cities *

Year	White LBWR	BLACK LBWR	% Higher for Blacks than Whites
1978	6.7	13.03	94%
1979	6.8	13.13	94%
1980	6.7	12.78	90%
1981	6.8	13.08	92%

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[1] 102:24
[2] 87:9
* For list of 32 cities see single asterisk cities in Appendix.

It is disturbing to note that while the white LBWRs remained fairly constant, the gap between whites and Blacks widened in 1981 after narrowing from 1979 to 1980.

Cities that experienced wide disparities in the IMRs between Blacks and whites tended to also show large differences in LBWRs. These included: Washington, D.C., Cleveland, Memphis and Detroit. A complete comparison is not possible because many cities that provided IMR data could not produce LBWR data broken down by race.

It is interesting to note that of the 32 cities studied, 47% showed increases in the incidence of low birth weight of Blacks from 1980-81. This again may be the beginning of a trend that could have serious implications for future infant mortality and morbidity.

The most disturbing data uncovered by the Public Advocates survey were the percentages of very low birth weight (VLBW) babies, those born weighing between 500 to 1500 grams (or approximately 1 pound and .6 ounces to 3 pounds and 4 ounces). These findings are displayed in Table E below.

TABLE E

Public Advocates Survey of VLBW Rates for 7 Cities*

YEAR	WHITE & VLBW	BLACK % VLBW	%HIGHER FOR BLACKS THAN WHITES
1979	1.3%	2.5%	86%

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* For list of 7 cities see double asterisk cities in Appendix.

(Table E Continued)

1980	1.2%	2.47%	105%
1981	1.17%	2.72%	132%

Data for 1978 were excluded due to an extremely small sample; data for 1979, 1980 and 1981 were based on 7 cities. Comparisons of years are useful even though only a small number of cities was studied. The data show that whites experienced a decline in the number of VLBW infants while their Black counterparts experienced an increase. Moreover, the gap between Blacks and whites seems to be rising at an accelerated pace. In 1979, Black women gave birth to VLBW babies at a rate that was 92% higher than that for white women. By 1981, that rate had increased to 132%. That means that the gap increased almost 50% within a span of only three years.

This trend is particularly disturbing because VLBW babies are the ones that pose the most serious risk of death. They also require the greatest expense due to a high likelihood of rehospitalization and future medical problems. It is discouraging to report that rather than observing improvements for these high risk infants, the record shows movement backwards.

4. Lack of Prenatal Care and Low Birth Weight

The chances of having a low birthweight baby are three times as great when an expectant mother receives no prenatal care.[1]

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[1] 136:24

The chances for low birth weight--and perhaps death-are also greater than normal if the prenatal care is not early, regular, and of high quality.[1]

In one study, infant death rates went up as the number of prenatal visits went down.[2] Another study concluded that infants born to women who had five or fewer prenatal visits had five times the neonatal mortality (under 28 days) of infants born to women who had six or more visits.[3]

Although Black mothers are more likely to have low birth-weight babies, they are less likely than white mothers to get early prenatal care (Table F). In 1978, one-fourth of all pregnant American women did not receive prenatal care in the crucial first three months (first trimester) of pregnancy. One-fifth of these women began prenatal care in the last (third) trimester, or received no prenatal care. Predictably, twice as many Black mothers (9.3%) as white mothers (4.5%) were in this last category of very late or no prenatal care.[4]

In 1980, 77.3% of white women received prenatal care in the first trimester as compared to 60.4% of Black women.

Racial disparities in low birth weight rates occur even among babies whose mothers receive no prenatal care. A study of 35,871 U.S. babies found that the low birth weight rate was

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1. 136:86
2. 43:858
3. 55:6-7
4. 104:77

15.3% among white mothers who had no prenatal care. The low birth rate for Black babies whose mothers had no prenatal care was 25.7%, or 68% higher.[1]

Table F below shows the national patterns of prenatal care for selected years 1970-1980. Consistent with other data presented, Black women are twice as likely as white women to receive poor prenatal care.

TABLE F

TRIMESTER PRENATAL CARE BEGAN, BY RACE, 1970, 1974, 1978 and 1980 -- UNITED STATES

Prenatal Care Began	1970	1974	1978	1980[2]
First Trimester (first three months):				
Black	44.4%	53.9%	60.2%	60.4%
White	72.4%	75.9%	78.2%	77.3%
Third Trimester (last three months) or No Prenatal Care:				
Black	16.6%	11.4%	9.3%	8.5%
White	6.2%	5.1%	4.5%	4.1%

Source: DHHS, Health, United States, 1982, p. 77, Table 24.

- Public Advocates Findings - Prenatal Care

Public Advocates attempted to collect data on prenatal care from all of the cities for which IMR data were collected. Statistics on prenatal care broken down by ethnicity and race, however,

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1. 46:890
2. 103:22

were found in only 6 cities. Thus, conclusions based on these findings may not be definitive. Nonetheless, a review of these findings does reveal certain patterns.

For the six cities reporting prenatal care by race, there was a slight decrease for 1978 to 1981 in the percent of Black and white women receiving first trimester prenatal care. For the same period, there was also a slight increase in the percent of women receiving no prenatal care. See Table G, below:

TABLE G

First Trimester Care For 6 Cities *

YEAR	WHITE	BLACK
1978	78.3%	62.8%
1981	74.7%	61.0%

No Care

	White	Black
1978	1.34%	2.58%
1981	1.39%	2.67%

Again, these data, based on a smaller than desirable sample are not conclusive; but they do indicate that a pattern might be developing, a pattern that would have a detrimental impact on America's health.

5. Teenagers and Low Birth Weight

Babies born to teenage mothers are more likely to be of low birth weight,[1] and to die in their first year of life[2] than babies born to mothers over age 20. Mothers aged 15 and younger are twice as likely to have low birth weight babies as are mothers aged 20 to 24. Even mothers aged 19 have LBW rates 27% higher than those who wait until their early twenties.[1]

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[1] 136:25

[2] 60:28

* For list of 6 cities see quadruple asterisk cities in Appendix.

Black mothers are more likely than white mothers to give birth before age 18,[2] and almost 8 times more likely to be under age 15,[3] which means that Black mothers have more births at an age which correlates with the highest percentage of LBW babies.[4] Black teenagers are also more likely than white teenagers to have a LBW baby.[5]

The high incidence of LBW babies among teenage mothers may be due to the "double disadvantage" of being immature physically and living at or near the poverty level. Families headed by young mothers are seven times more likely to be living below the poverty level than other families.[6] In 1975, $4.7 billion in federal welfare payments went to support mothers who had given birth as teenagers.[7] A higher percentage of Black infants than white infants are born to unmarried teenagers, which also increases the incidence of LBW.[8]

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[1] 60:29
[2] 46:889
[3] 50:4
[4] 46:889
[5] 60:29
[6] 60:33
[7] 60:32
[8] 77:10

The lower birth weights of babies born to teenage mothers contributes to higher neonatal (under 28 days) mortality rates, (NMR). Babies weighing 5 1/2 lbs. or less (LBW) born to teenage mothers had a NMR of 111.4 per 1,000 live births, while the NMR was only 2.4 per 1,000 live births where the infant weighed more than 5 1/2 lbs.[1]

a. Teenage pregnancies -- statistics

In 1978, there were over one million teenage pregnancies.[2] Seventy-four percent (847,000) were unintended[3] and almost 40 percent (434,000) ended in abortion.[4] More than one out of every 10 teenage women gets pregnant each year, and the proportion is rising.[5] In 1978, teenagers were responsible for almost one-sixth of all live births in the United States.[6]

In the mid-to-late 1970s, the United States teenage birth rate was higher than the rates for 29 other countries, including Singapore, Malaysia, Tunisia, and the Philippines. The U.S. rate is more than three times the rate for the Soviet Union, and about the same as the rate for Italy and Thailand.[7]

b. Teenage pregnancies -- outlook

Despite the enormity of the problem of teenage pregnancies in America, only four out of every 10 teenagers receive information about reproduction in the schools; only three out of 10 teenagers learn about contraception.[1] The Select Panel for the Promotion of Child Health found that although the proportion of 15 to 19 year-old women who had engaged in premarital sex increased from 30% to 50% (1971-1979), more than one-quarter of these teenagers had never used contraceptives, and close to two-thirds of this group became pregnant.[2]

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[1] 125:366-367
[2] 60:17
[3] 60:20
[4] 60:17
[5] 60:4
[6] 147:824
[7] 60:23

Once a teenager becomes pregnant, she is less likely than other pregnant women to get the early, high-quality prenatal care which could avert many of the damaging health consequences of early childbirth. Mothers under age 15 are 2 1/2 times more likely than mothers age 20-24 to get no prenatal care in the first trimester (first three months) of pregnancy, and nearly four times as likely not to get any care or to delay care until the last trimester. Mothers 15 - 17 are twice as likely as those age 20-24 to get no care in the first trimester and to have no prenatal care or none until the last trimester.[3]

- Public Advocates' Findings - Teen Pregnancy

The Survey revealed that for the 13 cities reporting teenage pregnancy data by race, the incidence of teenage pregnancy is falling for both whites and Blacks. While these figures may seem encouraging, the raw figures are not. In 1981, the year for which the survey population showed the lowest percentage of teenage pregnancies, the Survey revealed

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1. 60:20
2. 138:30
3. 60:59

that 26,505 babies were born to Black mothers between the ages of 15-19. In contrast, 11,452 babies were born to white mothers in the same age group.

In addition, the disparity between Black and white teenage pregnancy rates seem to be increasing. In 1978, the Black rate was 107% higher than the white rate of teen pregnancy. After falling to 100% in 1980, the gap increased in 1981 to 118% higher among Blacks than whites. These figures are shown in Table H below.

TABLE H

Teenage Pregnancy: Mothers Age 15-19 For 13 Cities*

YEAR	% WHITE TEEN PREGNANCY	% BLACK TEEN PREGNANCY	%HIGHER FOR BLACKS THAN WHITES
1978	13%	27%	107%
1979	12%	26%	116%
1980	13%	26%	100%
1981	11%	24%	118%

Perhaps the most troubling data analyzed in the area of teen pregnancies is that for mothers under the age of 15. Though a decrease may be detected for whites and Blacks in this age group, the incidence of teenage pregnancy for Blacks (in 1979) was 11 times higher than for whites. In 1980, the Black rate decreased to 4 times the rate of whites but increased to six times the white rate in 1981. As in the data for teens in the higher age group, these raw figures reveal the startling dimensions of the teenage pregnancy problem. In 1981, for the

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* For list of 13 cities see triple asterisk cities in Appendix.

13 cities studied, while 122 white mothers under the age of 15 gave birth to babies, 1,021 Black mothers in the same age group gave birth. The outlook for these young mothers, who have not completed their education and who are without means of financial security, is not promising.

6. Poverty and Low Birth Weight

There is a clear relationship between poverty and low birth weight babies,[1] and between poverty and higher risk of infant death.[2]

Infant death rates in 50 states and the District of Columbia were found to be higher in areas where a higher percentage of the population lived below the poverty level.[3] In Michigan, a state which from 1980 to 1981 experienced one of the greatest yearly increases in infant deaths since World War II, the Department of Health concluded that the rise in IMRs was consistent with poor economic conditions, high unemployment rates, and unprecedented cutbacks in social services.[4] "The poor, irrespective of race, experience a higher low birth weight rate because of the interactive effects of poor housing, diet, medical care and related factors."[5]

Many of the factors which are linked to low birth weight--

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[1] 136:25
[2] 43:858
[3] 52a:29
[4] 97:8
[5] 97:9

poor maternal nutrition, low educational level, race nonwhite, teenage pregnancies, and unwed mothers--are more predominant in poorer communities. "Put simply, poorer mothers have smaller babies, and smaller babies are at higher risk of early death."[1]

This may be one reason why Mississippi, one of the poorest states in the country, has for so many years ranked among the states with the highest infant death rates.

Poverty exerts such overwhelming pressure on mothers and infants, especially Black infants, that one child health specialist warned: "It should be noted at the outset that perhaps the most important reform [to reduce] infant mortality is the eradication of poverty and discrimination in America. The refashioning and improving of existing programs for the poor are only 'interim' solutions."

While petitioners agree that the eradication of poverty would most effectively reduce current high infant mortality rates, there are known solutions which although interim could drastically reduce the current infant death rates now.

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1. 110:1027

V. HIGH INFANT MORTALITY HAS CONSISTENTLY AND SUCCESSFULLY BEEN REDUCED THROUGH ADEQUATE PRENATAL CARE; NO MAGIC WAND IS NEEDED -- JUST COMMITMENT

A. Introduction

U.S. infant mortality rates have steadily decreased since the early 1900's. Improvements in sanitation and housing, declining fertility rates, expanded access to family planning services, better nutrition and health care, and advances in medical technology have all enhanced an infant's chances for survival.

Nonetheless, the U.S. still lags far behind other industrialized nations in reducing infant mortality to the few medically unpreventable deaths. This troublesome disparity reflects the persistent prevalence of low birth weight babies, which accounts for fully two-thirds of all U.S. infant deaths.[1] A recent article published in JAMA concluded: "...unless the proportion of U.S. babies born at low birthweight is reduced, the U.S. will likely retain its relatively poor international rank."[2]

Despite this challenge, the U.S. health delivery system provides substantial incentives for technological intervention to save low birth weight babies while failing to prevent low

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1. 139:15
2. 47:990

birth weight in the first place. Not surprisingly Congress' 1980 Select Panel addresses this failure:

> "Although improvement in survival among low birthweight infants has contributed a great deal to reduction in infant mortality, a decline in the incidence of low birthweight would result in still lower mortality and morbidity. A balanced approach to prevention of low birthweight and improvement in survival of low birthweight infants is clearly required to assure continued improvement in infant health."[1]

Indeed, dependence on technology to save low birth weight babies has gone just about as far as it can to reduce death and illness rates.[2] Only the increased availability of prenatal care to those mothers who predictably bear low birth weight babies -- low income women, minorities, teenagers -- will further reduce the U.S. infant mortality rate.

Prenatal care prevents a myriad of disabilities, illnesses and death. Universal availability of prenatal care, along with the help of medical technology when needed, is a simple, cost-effective, balanced and humane way of giving every newborn the healthiest start in life.

B. Adequate Prenatal Care Has Proven Successful in Increasing Birth Weights

> "The effectiveness of prenatal care in reducing low birthweight . . . has been

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[1] 76:33

[2] 76:32-33, 93:ix-xi; 112:126; 47:990

> so well demonstrated in various well-controlled studies that even the most skeptical reviewers of the health services literature would agree that this form of preventive care is one of our most valuable in promoting child health." [1]

Evidence from other countries demonstrates the strong relationship between widespread availability of quality prenatal care and the birth of fewer underweight babies. In Sweden, for example, comprehensive prenatal care is uniformly of high quality and available to all. Between 1970 and 1976, when the U.S. low birth weight was 7%, Sweden's was 4.1%. This includes babies born to Sweden's growing immigrant population[2] which constitutes nearly 10% of the births.

When U.S. pediatricians at the recent U.S.-China Joint Health Committee meeting suggested a cooperative study of the low birth weight issue, the Chinese "indicated that they simply did not have enough of that problem to merit study." In China, "every effort is made through nutrition, social support, medical care and other means to assure a mature, healthy infant and mother."[3]

Many of the techniques that have worked so well in other countries have been used in the U.S. with equally positive results. For example:

-- A Maternal and Infant Care (MIC) project in New York City reduced the rate of low birth weight infants from 21.9% to 15.6% in only two years.[4]

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1. 138:165
2. 139:15
3. 12
4. 54

- -- The low birth weight rate for participants in a Cleveland, Ohio MIC project was 11.7% compared to 14% for those born to a comparable group of women who were not in the program. The program also reduced school drop-out rates after delivery and decreased the subsequent pregnancy rate from 7.9 to 3.5%. [1]
- -- In 1973, the St. Paul, Minnesota MIC program began a comprehensive prenatal school-based clinic for teens, 13-18 years old. Low birth weight infants were born to 5.5% of those mothers compared to 13.9% in a comparable group of teens receiving care in a non-school MIC clinic.[2]
- -- In 1972, a nurse midwifery program was established in a four-county area of rural Georgia to provide prenatal care to low-income women who had no private physician. The program nearly halved the incidence of low birth weight in that region from 24% to 13.8%.[3]
- -- The Obstetrical Access Project in California provided comprehensive prenatal, delivery and postpartum care to women in thirteen underserved counties from 1979-1982. Preliminary data for the project's first years show that OB Access patients had half the incidence of LBW compared

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1. 131:155
2. 6:33
3. 118:495

to a matched group of Medi-Cal patients (3.9% v. 7.3%). Striking differences were found among OB access patients in direct relation to the amount of care received. LBW rates were substantially lower for women who began prenatal care in the first trimester, as well as for those who received the full package of comprehensive services (2.8%) compared to those who only had a partial package (7.2%).[1]

-- Lincoln Hospital located in the impoverished South Bronx established a special clinic with MIC funds to provide comprehensive, family-centered prenatal care for Hispanic and Black teenagers. In the first year of the program, LBW was cut by two-thirds, from 18.1% in 1976 to 6.3% in 1977. [2]

-- Su Clinica Familiar, a migrant primary health care clinic, was established in 1972 in the Texas Rio Grande Valley. The clinic offers culturally sensitive, comprehensive perinatal health care to its predominantly Mexican-American clientele. The incidence of LBW among clinic deliveries was 4.4%. The rate of premature births was 3.5%, contrasted to 7.6% for all births in Texas, and 7.4% for the U.S. in 1976.[3]

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1. 91:52-59
2. 44:32
3. 100:26

-- The Oakland Perinatal Health Project (OPHP) in Oakland, California has been providing comprehensive clinical, outreach and support services to low income pregnant women and their infants up to one year of age since 1978. A December 1982 report evaluating three years of the program found that for OPHP patients who had ten or more prenatal visits, the LBW rate was 3%; for those with 5-9 visits, 10.1%; and for less than five visits, the LBW rate was 12.4%. There was a 13.6 gram increase in birth weight for each prenatal visit.[1]

These are but a few examples of the hundreds of projects which have demonstrated prenatal care's powerful capability to reduce low birth weight.

C. Prenatal Care Also Helps Prevent Mental Retardation and Other Disabilities

Mental retardation is highly associated with prematurity and low birth weight. LBW babies bear an increased risk of cerebral palsy, deafness, mental handicap, epilepsy, autism, congenital malformation, as well as less severe handicaps known as "minimal brain dysfunction."[2] Women at highest risk of bearing mentally retarded children are younger than 16, older than 40, inadequately nourished during pregnancy, obtain poor or no prenatal care, and have few economic resources.[3]

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[1] 3:1-2
[2] 153:50
[3] 24:2-3

President Kennedy's Committee on Mental Retardation concluded that at least fifty percent of mental retardation originates prenatally or just around birth and could be prevented by improved maternal and infant care alone.[1] In addition, recently developed medical technology not commonly available when the Kennedy Committee convened further enhances the preventive capability of prenatal care. Tests can detect genetic abnormalities such as Down's Syndrome (responsible for nearly 30% of all severely retarded children in the U.S. and Western Europe),[2]sickle-cell anemia (primarily affecting Blacks), neural tube defects (spina bifida, a condition of spinal cord defects), and anencephaly (a condition where the fetus has no skull).

Further prevention of retardation and disability, then, requires enhanced availability of comprehensive prenatal care.[3]

D. What Constitutes Comprehensive Prenatal Care?

The successful programs mentioned above all provide comprehensive prenatal care. These services include clinical checks and laboratory tests, nutritional assessment and counseling, health education, childbirth preparation, psychological counseling, and education in breastfeeding and family planning. A comprehensive approach promotes optimum physical and emotional

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1. 153:8
2. 33:216
3. 153:17

well-being during pregnancy, provides personalized education and counseling, detects, treats and monitors any condition that could endanger the life or threaten the health of either the pregnant woman or fetus, monitors fetal well-being and growth, and prepares the woman for labor, delivery and care of her newborn.

Comprehensive prenatal care is usually provided by one or several health care practitioners working as a team with a physician including nurse-midwives, nurse practitioners, public health nurses, physician's assistants, nutritionists, health educators and social workers. These practitioners emphasize prevention and education. Ideally, they are culturally sensitive, bilingual when appropriate, and respectful of clients and their needs. They provide ample time to listen to an individual patient's concerns, answer questions and make timely referrals to other practitioners or specialists when necessary.*

1. Timing of prenatal care

The first prenatal visit should be made within the first three months of pregnancy. For healthy, normal women, prenatal appointments are generally scheduled on a monthly basis through the seventh month, every two weeks during the eighth month, and once a week in the ninth month of pregnancy.

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* According to the National Ambulatory Medical Care Survey, 32% of prenatal care visits in private physicians' offices involved five minutes or less, and 69% involved 10 minutes or less. There was some medical counseling in 25% of the visits and some nutrition counseling in 14%. 138

2. Clinical Prenatal Care

The first prenatal visit includes taking a complete medical history of the pregnant woman and her family, a Pap smear, a gonorrheal culture (gonorrhea can cause blindness if present in the birth canal during delivery), a pelvic exam, blood pressure and diagnostic laboratory tests. Three-quarters of the factors that lead to low birth weight can be evaluated in the first visit and appropriate intervention such as nutrition counseling, can begin early to reduce risks.[1]

Prenatal visits routinely include blood pressure checks and blood*and urine**lab tests to screen for a variety of conditions which, if left undetected and untreated, can cause major problems to the woman and fetus before, during and after birth.

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* Blood tests detect anemia (a cause of low birth weight), rubella (causes birth defects, such as heart disease, deafness and mental retardation if contracted in the first trimester), syphillis (deformities, prematurity, fetal death), and Rh factor incompatibility (causes fetal heart failure, stillbirth, severe anemia, deformity or mental retardation if an Rh negative woman, carrying an Rh positive fetus, has not been properly treated to prevent fetal damage should blood mixing occur before or during labor.)

** Urine tests determine excessive sugar (diabetes), protein (toxemia), and urinary tract infections. About 60% of all cases of urinary tract infections (kidney or bladder) can be prevented through early detection.[2] Untreated, the infection increases the likelihood of premature birth and perinatal mortality. In one Maternal and Infant Care Project, urinary tract infections occurred more than twice as often in the comparison group as in the study group. [3]

1. 138:165
2. 101:216
3. 6:34

Pregnant women who have little or no prenatal care often suffer from anemia and toxemia, two conditions commonly related to LBW and ones easily detected through routine blood and urine tests. The most frequently reported risk for women in the California Obstetrical Access Project, for example, was anemia.[1] Since greater demands are made on the blood supply during pregnancy, anemia, a form of iron deficiency, is fairly common. Although all women are prone to anemia and may require additional iron during pregnancy, low income women who have closely spaced pregnancies or improper diet are at highest risk.[2] Many of these women are already anemic before pregnancy and never catch up when they become pregnant. If left untreated, severe iron deficiency anemia can result. This condition is associated with increased LBW, since the baby does not receive sufficient nourishment.

Anemia can easily be controlled with good prenatal care, iron supplementation and foods rich in protein, vitamins and iron. This was recently demonstrated by the Oakland Perinatal Health Project. Of the prenatal clients who had a low hematocrit score (a measure of the relative amounts of iron in the blood which carry oxygen to all cells in the body) at their first prenatal visit, 91.7% had a healthy rating by their final visit.[3]

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1. 91:64
2. 101:216
3. 3:30

Toxemia occurs only in human pregnancies. Rarely seen before the 24th to 30th week, toxemia is characterized by high blood pressure (hypertension), protein in the urine, and swelling. About 7% of pregnant women in the U.S. develop toxemia.[1] If not treated, it can progress to its most severe form, eclampsia, causing maternal convulsions and coma, which can result in permanent disability or death for mother and infant. Toxemia is most prevalent among low income women who do not have access to adequate prenatal care.[2] Diabetic, hypertensive, adolescent women, those carrying more than one baby, or who suffer from poor nutrition and stress, are especially prone to developing toxemia. This condition contributes to LBW infants, whose growth is retarded because the placenta is unable to provide sufficient circulation to the fetus. High quality prenatal care, good nutrition and adequate rest are the best ways to prevent toxemia. An MIC Project for teenagers in Minnesota found the toxemia rate for adolescents in the study group to be 11.1% while the rate for those in the comparison group was 16.7%.[3]

Diabetic mothers tend to have either very large or very small babies which are at increased risk of perinatal death, usually from serious respiratory problems, one of the most life-threatening complications in LBW infants. These risks, too, can be greatly reduced with early, continuous, comprehensive care, insulin and diet.

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[1] 18:75
[2] 18:81
[3] 6:34

E. Additional Components of Comprehensive Prenatal Care Contribute Significantly to Improving Pregnancy Outcome

1. Nutrition

The health of an infant at birth reflects the nutritional status of the mother before and during pregnancy. Recently, the role of adequate maternal nutrition has undergone considerable scrutiny. Many health experts now concur that the quality and quantity of food consumed during pregnancy is critically important, particularly for low income women who have few resources and possibly a lifetime of poor nutrition.[1]

Infant birth weight is significantly affected by the mother's weight before pregnancy, weight gained during pregnancy, and the age of the baby at birth.[2] Fully one-third of LBW in the U.S. is believed to result from retarded fetal growth during pregnancy.[3] Poor nutrition accounts for at least 57% of LBW in Black newborns.[4] Nutritional deficiencies in pregnancy are also related to increased vulnerability to illness, anemia and mental retardation.

Over the last 35 years, various food supplement programs have demonstrated that improved nutrition makes a big difference. In 1948, the Montreal Diet Dispensary began providing milk, eggs and oranges to low income women registering for prenatal care in public clinics. Of 1736 participants from 1963 to 1972, 80% of the women suffered from poor nutritional status when enrolled, and 25% were underweight by 5% or more when they became pregnant. Significant increases in birth weight for all women considered to be at special risk (teens, underweight and overweight women) were achieved. Furthermore, the earlier the intervention began, the better its affect on birth weight. The rate of LBW for mothers in the program for 1-12 weeks was 9.8%, compared to 4.07% for women who received supplementation over 20 weeks. Teens in the program had a LBW rate of 3.3% contrasted to 10% in a comparable group that did not receive food supplements. Perinatal mortality dropped from 26.6 to 8.3/1000 live births. The rate of developmentally disabled infants born was lower than the average for all of Canada. This program was one of the first to demonstrate how the poverty cycle can be broken and the effects of previous poor pregnancies mitigated.[1]

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[1] 67:1
[2] 72:7,8
[3] 127:31
[4] 65:347

In the U.S., the Women, Infants and Children (WIC) food supplement program was authorized by Congress in 1972. Modeled after the Montreal Diet Dispensary program, WIC provides food and nutrition education to low income, pregnant and nursing

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1. 67:1

women, infants and children up to age five.[1] WIC attempts to reach those individuals who, because of inadequate nutrition, face an increased risk of complications during pregnancy or poor fetal growth and development. WIC's goal is to decrease the rate of LBW infants who require hospitalization in costly neonatal intensive care units. By 1977, WIC was serving over one million women, infants and children at an annual cost of about $423 per participant.

Evaluations of the WIC program establish incontrovertibly its cost-effective, successful role in preventive health care.

> "In Michigan, 30 percent of the high risk women were anemic before they came into the WIC program. After participation, the figure was six percent . . . . In the Pennsylvania WIC program, the infant death rate was 10.6% before participation . . . it was zero after participation. Premature birth rates decreased from 12.8 to 1.6 percent. And pregnancies with complications were reduced from 30 to 17.6 percent".[2]

Six WIC sites and three non-WIC sites in Massachusetts were studied between 1973-78 by the Harvard University School of Public Health. Information was collected on a total of 1328 pregnant women, 918 WIC and 410 non-WIC participants. The LBW rate for WIC babies was 3.4%, compared to 14.6% for non-WIC infants.[3] Further, birth weight improved with each additional

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1. 71
2. 52:8
3. 71:9

month of food vouchers. The authors reported, "If the full complement of nine WIC vouchers were received by prenatal participants, birthweight would increase by eleven ounces."[1] The authors showed that for every dollar invested in the WIC program, at least three were saved in later treatment costs.[2]

Programs providing comprehensive prenatal care to low income women routinely include nutrition evaluation, counseling and when necessary referral to WIC or other food supplement programs (e.g., food stamps). The nutrition component of the California Obstetrical Access pilot project was so successful (85% of the women in the program participated) that a recent cost-effectiveness evaluation of the program recommended expanding the Medi-Cal (Medicaid) obstetrical benefit package to include nutrition, as well as other support services.[3]

National health goals established by the federal government for 1990 include marked improvement in the nutritional status of pregnant women based on the assumption that "current efforts to ensure an adequate supply of food will be continued and extended (WIC and food stamps)."[4]

2. Health Education

Smoking, alcohol and use of drugs during pregnancy also affect low birth weight, birth defects, retardation and

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1. 72:35
2. 71:45
3. 81:1-3
4. 139:18

disability. While many women are quite receptive to practicing good health habits during pregnancy, many are unaware of the adverse consequences of smoking, alcohol, and drugs. Comprehensive prenatal health education should cover: smoking, alcohol and drugs, as well as nutrition counseling, the physiological aspects of pregnancy, safe remedies for the discomforts of pregnancy, counseling for stress, environmental hazards at home and in the workplace, breastfeeding education, family planning including the importance of spacing births, and childbirth preparation. Ideally, educational sessions are scheduled to coincide with regular prenatal appointments.

a. Smoking

The U.S. Surgeon General reported in 1979 that the detrimental effects of smoking cigarettes during pregnancy include increased risk of spontaneous abortion, perinatal death, prematurity, low birth weight, shortened body length, smaller head size, and potential long term impairments in physical growth, mental development and deficiencies in behavioral development in children at least up to eleven years of age.[1] Sudden Infant Death Syndrome (SIDS) is also associated with maternal smoking.[2]

Abundant evidence causally links maternal smoking to low birth weight. Infants born to mothers who smoked during pregnancy weigh about 200 grams less than those born to women who did not smoke. Fully 21-39% of the incidence of LBW is attributable to maternal smoking.[1]

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[1] 137:8
[2] 59:2

The more a woman smokes during pregnancy, the lower the birth weight of the newborn. Conversely, if a woman stops smoking at any time during pregnancy, the risk of delivering a low birth weight baby becomes similar to that of a nonsmoker.

Measured differently, an estimated 14% of all premature births in the U.S. are attributable to maternal smoking.[2] These preterm births result from other complications of pregnancy, labor and delivery which increase directly and significantly as the level of maternal smoking increases.[3]

The possibility of perinatal death is increased by 20% among smokers of less than a pack a day, and 35% among those who smoke more than a pack a day.[4] Perinatal death associated with maternal smoking involves fetal deaths due to oxygen deprivation, and neonatal deaths due to prematurity and related respiratory complications.

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[1] 137:11,27
[2] 137:42
[3] 96:495
[4] 96:495

The risks associated with maternal smoking are compounded by the effects of poverty, prior perinatal death,[1]poor nutritional status, anemia,[2] and lack of prenatal care.

b. Alcohol

Alcohol is the most commonly used drug in the U.S. Not surprisingly, alcohol-related problems are among the nation's most serious health problems.[3] In light of growing evidence that intrauterine exposure to alcohol is a leading cause of birth defects and associated mental retardation,[4] the American Medical Association officially recommended that pregnant women abstain from alcohol.[5]

Fetal damage due to alcohol occurs differently at different stages of pregnancy:

> "During the first trimester, alcohol may alter cell membranes and the embryonic organization of the tissue. Throughout gestation, direct effects of alcohol on the metabolism of carbohydrates, lipids, and protein probably retard cell growth and division. Alcohol also interferes with the active transport of amino acids across the placenta, reducing the availability of essential nutrients to the fetus . . . The third trimester is the time of most rapid brain growth. . . . High blood alcohol level concentrations during this period may impair central nervous system growth and future intellectual and behavioral development".[6]

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[1] 137:28
[2] 96:501
[3] 106:630
[4] 132:251
[5] 119:33
[6] 121:4

Fetal alcohol effects range from minor alterations in growth at one end to "fetal alcohol syndrome" at the other.[1] These effects include low birth weight,[2]prematurity,[3] spontaneous abortion,[4] fetal distress and neonatal depression,[5]developmental abnormalities,[6]mental retardation, and behavioral and learning problems.[7] As with cigarette smoking, decreasing alcohol consumption at any time, even in the third trimester, will significantly improve chances of having a healthier baby.[8]

Once problems drinkers are brought into the health care system, health educators skilled in eliciting information can play a role in changing behavior.* During 1974-79, more than 1700 women were interviewed at Boston City Hospital when they first registered for prenatal care. Women who reported heavy use of alcohol were scheduled for counseling sessions which coincided with routine prenatal visits. Fifty-six

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1. 86:1154
2. 86:1155; 109:138-139
3. 109:529
4. 62:174; 78:179
5. 130:143
6. 140:62
7. 126:980
8. 121:6; 132:256

* One study found that physicians are generally reluctant to ask prenatal patients about alcohol because they lack the time or knowledge about how to handle problem drinkers who are perceived as "difficult cases." 121

percent of the 39 women who attended three or more sessions achieved abstinence or significantly moderated their drinking before the third trimester. Their newborns were compared with infants of mothers who continued drinking heavily throughout pregnancy. Improvement in growth, measured by birth weight, height and head size was consistently associated with reduction of alcohol use.[1]

c. Drugs

Americans spend $5 billion every year on the more than 350,000 varieties of over-the-counter drugs.[2] The majority of these have not been tested for safety and effectiveness by the U.S. Food and Drug Administration, and drug manufacturers have not adequately determined the potential damaging effects of these drugs on maternal and fetal health. Yet, thousands of these products are used regularly to relieve the discomforts of pregnancy.

Self-diagnosis and treatment with over-the-counter drugs is an unquestioned part of U.S. lifestyle. Unfortunately, many pregnant women are unaware that no drug, either prescription or non-prescription, has been proven safe for a developing fetus.[3] The most commonly used non-prescription drugs implicated in birth defects and other complications are aspirin (damage of kidney, liver, central nervous system, bleeding), acetaminophen, or non-aspirin (kidney and liver damage, anemia, fetal death from toxicity), antihistamines (cleft palate, limb deformities), barbiturates (newborn addiction and withdrawal, liver and brain damage, respiratory distress), and cold and cough medicines (liver and bone marrow damage, blood clotting deficiencies).[1]

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[1] 121:2
[2] 30:1
[3] 84:19, 42:843

The effects of drugs taken during pregnancy depend in large part on when they are taken, the number and kind of drugs taken in combination, and the timespan during which they were taken. Fetal growth follows a specific developmental sequence. Since every part of the body has a critical formation period, anything that interferes with that process will result in arrested or deformed development. This was tragically seen during the early 1960's when women who took the poorly-tested drug Thalidomide to prevent nausea in the first trimester gave birth to nearly 6,000 limb-deformed infants worldwide.

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There are few studies which have isolated the effects of prenatal education on drugs, alcohol or smoking from the other components of health education usually included in comprehensive prenatal care. What is known, however, is that comprehensive

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1. 123:31-34

prenatal care has significantly reduced low birth weight, much of which is caused by use of drugs, alcohol and tobacco during pregnancy. Moreover, as many health practitioners can attest, once informed of hazards, pregnant women are frequently highly motivated to protect their fetuses, even if such protection means changing lifelong habits which stubbornly persisted when only the mother's health, not her child's, was at stake. In addition to educating pregnant women, efforts to reduce drug, alcohol and tobacco use during pregnancy can be enhanced through heightened public awareness and increased popular support for the pregnant woman who changes her health habits at this critical time.

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F. Underserved Pregnant Women Must be Brought Into the Health Care System

1. Women Who Are Most At Risk

While for most women, pregnancy and childbirth are a normal, healthy process, a time of personal joy and sharing with families and friends, problems do sometimes arise. Though potentially serious for mother and child, they can usually be controlled if identified, treated and monitored early enough with prenatal care. At no other time, then, is appropriate health care more important than in the nine months before birth.

Unfortunately, the advantages of prenatal care are not shared equally by all pregnant women in the U.S. In fact, the women who would benefit most from early quality prenatal care often have the most difficult time obtaining it. Teenagers, low income, minority and undocumented women are those most likely not to get needed health care, putting them at greatest risk of bearing low birth weight babies vulnerable to illness, disability and death.

The federal government has set 1990 as the year in which 90% of all women in any county or racial or ethnic group should begin prenatal care in the first trimester of pregnancy.[1] Tremendous progress must be made in the next seven years to reach that goal. In 1978, 25% of pregnant women had no prenatal care in the first trimester.[2] Only 55% of American Indian women began prenatal care in the first three months of pregnancy in 1978.[1] In 1977, only 59% of California's Hispanic women who bore children were able to obtain prenatal care in the first trimester.[2] And in 1979, while 79% of white women began prenatal care in the first trimester, only 62% of Black women were able to obtain early care.[3]

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[1] 139:18

[2] 139:15

In 1978, over half of all pregnant teenagers in the U.S. did not get prenatal care until the second trimester.[4] Teens are more likely to conceal or deny being pregnant, be fearful of admitting to sexual activity, have stressful relationships with their families, become isolated, leave school, not understand the importance of early prenatal health care and not know where to find services that are available.[5] Although pregnant teens are generally characterized as high risk and do have high complications rates, many of the risks associated with adolescent pregnancies can and have been greatly reduced with early prenatal care.[6] It is more the "social rather than the biological side of health care that places the pregnant teenager at risk."[7]

The specific problems that constitute an "at risk" pregnancy for women with inadequate or no prenatal care include

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1. 139:18
2. 95:5
3. 104:6
4. 60:59
5. 21:52
6. 21:54
7. 79:18

medical as well as socioeconomic and psychological factors. Untreated anemia or infections, short intervals between pregnancies, inadequate weight gain, poor nutrition, smoking, misuse of alcohol and drugs, severe emotional problems, inadequate income, chronic domestic violence, and lack of an emotional support system are but a few examples of the factors that contribute to poor pregnancy results. Being at risk, however, is by no means a static condition. Accessible, quality prenatal care helps women who are initially at risk for medical, social, economic or psychological reasons to become low risk or even normal.

2. Barriers to obtaining adequate prenatal care

Among the major reasons low income and minority women do not or are unable to obtain early prenatal care are an unawareness of preventive health care's importance, financial, uneven distribution of primary health care providers, language and cultural barriers, undocumented status and transportation difficulties.

a. Understanding the importance of prenatal care

> "Sometimes health care programs must do more than provide an open door. They must take the initiative to find, educate and help bring in mothers and children to receive care."[1]

It is often difficult to convey the value of preventive health care in communities where people lead crisis-ridden lives

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1. 138:180

due to poverty, poor housing, unemployment, and daily struggles to obtain food.[1] In this context, health care only becomes a priority in an emergency, and the significant relationship of prenatal care to the outcome of pregnancy is not necessarily known.

In some cultures, pregnancy is viewed as a natural condition requiring no medical attention. A 1970 survey of 1500 low income, predominantly Mexican-American women in San Antonio, revealed that only one-third of those questioned appreciated the importance of prenatal care.[2]

The Coalition to Fight Infant Mortality, petitioners in this action, advocate more community education.

> "A lack of community awareness about the need for early and consistent prenatal care prevents many women from seeking such care. A lack of education programs about their prenatal health needs also prevents many women from properly maintaining their health during pregnancy. It is not solely the responsibility of these women 'to become educated' about their perinatal needs. Health education is the responsibility of the health care system and must be a major component of . . . perinatal services."[3]

Thus to be effective, programs offering quality prenatal care to low income women must be able to bring women into the health care system. This requires active and ongoing community education and outreach.

The Denver, Colorado MIC program involved community outreach workers in recruiting clients into prenatal care. The outreach workers educated the clinic's professionals about the community's lifestyle and values and conveyed to the community the importance of the health program. After only four months in one neighborhood, over 60% of the MIC clinic participants had been referred by the outreach workers and use of clinic services was 12% higher in neighborhoods with outreach workers. Fifty percent of the patients were seen in the first or second trimester in neighborhoods with outreach workers, compared to 32% in unserved neighborhoods.[1]

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[1] 73:997
[2] 53:38
[3] 31:84-85

When prenatal programs are acceptable to a community, the response can be overwhelming. Mission Neighborhood Health Center in San Francisco found that its bilingual/bicultural prenatal health education classes "proved to be one of the major attractions of our project ... the major means of advertising was word of mouth through the patients themselves .... We didn't even need to do as much advertising as we did initially to get people involved."[2]

Yet, even when women do understand how important prenatal care is, numerous other barriers can prevent them from obtaining services.

b. Financial barriers to prenatal care

> "Despite the positive effects of Medicaid and various formula and project grant programs, financial barriers remain responsible for many of the most serious

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[1] 73:1001
[2] 144:78-79

> and persistent inequities in maternal and child health care."[1]

The high cost of health care is cited repeatedly as the predominant barrier preventing low income pregnant women of all ages and ethnic backgrounds from receiving needed prenatal care.[2] Medicaid provides coverage for fewer than 75% of the poor in the U.S.[3] It has been estimated that 220,000 need Medicaid coverage for pregnancy and delivery but are not eligible. Of these women, approximately 60,000 are pregnant for the first time.* When the infants are born, the mothers will then qualify for AFDC and Medicaid but during the crucial early months of pregnancy in many states these women are not Medicaid eligible. The remaining 160,000 women are financially needy but for a variety of reasons, including living with a poorly paid but employed spouse, do not qualify for Medicaid.

But even having Medicaid is no guarantee that pregnancy health care can be found. Physician participation in the Medicaid program is strictly voluntary. Each year, fewer and fewer physicians are willing to accept Medicaid patients.[4] This occurs despite an oversupply of doctors in the U.S.,[5] particularly specialists such as OB/GYNs. In California, for example, the number of OB/GYN's accepting Medi-Cal patients dropped from 65% in 1974 to 46% in 1977.[1] And, the unavailability of doctors for Medicaid patients is exacerbated by the tendency of physicians to concentrate their practices in populated, affluent metropolitan areas of the country, leaving a severe health care shortage in the inner cities and rural areas.

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[1] 138:37
[2] 95:2; 31:18; 23:48; 53:39; 21:35-40
[3] 138:31
[4] 29
[5] 138:13

* H.R. Rep. No. 568, 96th Cong., 1st Sess. 85 (1979).

Physicians' reluctance to accept Medicaid is mainly rooted in the disproportionately low reimbursement rate (approximately 1/3 of the private fee paid)[2] for normal prenatal care and delivery. Yet in 1981, a total of $255 billion was spent for health care in the U.S.; 42.7% of that total was paid with public dollars.[3] Despite the huge amount expended, only a fraction was allocated for the preventive care needed by pregnant women.

> "Foremost is the fact that preventive services are generally not covered by either private or public insurance ... Present incentives drive many providers to offer the most expensive and least prevention-oriented types of care, which are particularly inappropriate for children and pregnant women."[4]

The situation is even more desperate for women who are not eligible for Medicaid. These women are forced to rely on local public health care provided by counties and limited-term Maternal and Child Health programs funded by the federal government and the states. In the absence of these services, women may have no other option than to forego prenatal care altogether, wait until the last month to get some care, or show up at a hospital emergency room in labor.

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[1] 23:123
[2] 21:253
[3] 63:1
[4] 138:31

Many physicians, hospitals and even local public health departments will not accept non-insured women without advance, out-of-pocket payment.[1] One year after Los Angeles County began charging uninsured county patients $20-30 for each prenatal visit, one county hospital reported that 65% of women delivering there had no prenatal care. The broken prenatal appointment rate in the county increased by 73%, and 147% during the ninth month of pregnancy. Most telling, the number of premature births at the county's three hospitals rose by 7.4%.[2]

c. Limited access to primary care and nurse-midwives

Limited and unequal access to primary medical care in the U.S. has been a growing concern for the last two decades. The federal government and Congress have attempted to correct this imbalance through the development and financial support of formal education programs to train a variety of mid-level practitioners (nurse-midwives, nurse practitioners, physicians assistants) for work in expanded maternal health primary care roles.*

These efforts have suffered cutbacks. Even when more

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1. 21:36
2. 36:25

* Nurse Training Act, 1964, National Health Service Corps. Act, 1970, Comprehensive Health Manpower Training Act, 1971.

federal dollars were available, only a small number of nurse-midwife students were accepted by programs for training each year-- not enough to meet the desperate need for practitioners in maternity care, particularly for low-income women. In California, for example, the three nurse-midwifery training programs accept a total of only 25 applicants annually.[1]

Unfortunately, no matter how many more are trained, the benefits of nurse-midwives will not be realized until barriers which prevent their full utilization are removed. The GAO and the House Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce both found numerous factors which prevent nurse-midwives from using their full range of skills. Those barriers identified are: physician resistance, limited availability of physician backup, restrictive state licensing, third-party reimbursement, and the inability of nurse-midwives to obtain hospital staff privileges.

In a 1979 report, the GAO recommended that "...HEW encourage a greater use of nurse-midwife/obstetrician teams, help eliminate barriers which preclude nurse-midwives from practicing in hospitals, and provide additional training funds for nurse-midwives, by giving such training higher priority for use of existing funds and/or seeking additional funds from Congress."[2]

d. Language and cultural barriers to health care

The scarcity of health providers who serve non-English

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1. 21:175
2. 134:263

speaking clients in their own language presents a serious obstacle to many pregnant women. Inability to communicate with a health care practitioner puts women at unnecesary risk and effectively renders health care inaccessible.

> "First, the limited English speaking person is ignorant of various benefits and services since information is primarily disseminated in English. Second, if the limited English speaking person has some knowledge of . . .her entitlements, since eligibility determinations are part of [establishing] their needs with English-only forms . . . she may be found ineligible incorrectly. Then, assuming that the limited English speaking person makes it through these two hurdles, diagnosis and treatment is also impossible due to monolingual English professional staffs. Family members and volunteers serving as interpreters are not adequate."[1]

In some instances, it is culturally unacceptable for women to receive care from a male physician. Often Hispanic, Southeast Asian and Middle-Eastern immigrants, accustomed to receiving health care from women practitioners, are reluctant to seek prenatal care from male providers. In a survey conducted in San Antonio, Texas, 35% of the Hispanic women respondents expressed "strong concern or fear regarding physical examinations",[2] In another study, it was felt that, in part, Hispanic women received late or no prenatal care due to "insufficiency in numbers of Hispanic health care providers who might establish cultural rapport".[3]

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1. 108
2. 53:39
3. 95:2

Racial and class discrimination further discourage many women from seeking and obtaining prenatal care. In a survey conducted by the Coalition to Fight Infant Mortality, the third greatest barrier identified was "attitudes and insensitivity of caregivers, and in particular the negative attitudes towards women and ethnic minorities".[1]

e. Undocumented women

There are an estimated 7.4 million undocumented people in the U.S. of which about 60% are from Mexico.[2] For undocumented women, the usual problems associated with getting prenatal care, i.e., money, availability of services, awareness of the value of care, language, and discrimination, are compounded by fear of deportation which prevents all but a few undocumented people from using public health or social assistance services. California estimates that only 1% are on welfare and only 4% use public schools or apply for unemployment benefits.[3] In 1979, an estimated 90% of undocumented people in the U.S. were employed.[4] In California alone, undocumented workers contributed $1.5 billion in state taxes in 1979.[5] Yet, even women who are legal residents and eligible for Medi-Cal are reluctant to apply for fear of endangering other family members who are undocumented.[6]

Most of the 1.5 million undocumented persons who reside

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1. 31:16
2. 23:156
3. 23:156
4. 23:157
5. 23:159
6. 21:50

and work in California[1] turn to county health services. The closure of 30 county hospitals since 1966 has foreclosed access to health care for many undocumented persons, particularly in the rural and agricultural areas of the state.[2]

Undocumented women's need for increased access to maternity care was starkly documented in California's Obstetrical Access Project. While the planners had anticipated that the vast majority of the participants would be Medi-Cal, in fact 53% of the program's 1,980 registrants during its first year of operation were low income, non-Medi-Cal eligible. Hispanics comprised nearly half of all OB Access enrollees.[3]

f. Transportation

> "Sometimes health care providers and facilities are only theoretically available. Long distances or high costs in getting to a source of care can be major barriers to obtaining needed health services. For the poor, the distance appears to be a significant deterrant to seeking preventive care."[4]

Reliance on public transportation entails high cost and long travel time to facilities located inconveniently in relation to public transit routes.[5] For mothers who cannot arrange childcare, traveling with small children intensifies the stress of a long trip.

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[1] 23:156
[2] 21:2
[3] 91:3,27
[4] 138:181
[5] 21:32

Fifteen hundred women surveyed in San Antonio indicated that transportation problems were among the factors which frequently interfered with their use of prenatal care services.[1] Another study reported that low income people spent 58% more time traveling to medical facilities and waiting to see a doctor than people with adequate financial resources.[2]

Transportation is even more problematic in rural areas. Poor women in central California, dependent upon public buses transfer several times to get to their prenatal appointments: many are unable to return home the same day.[3] In many rural communities, there is simply no public transportation at all. One MIC project in Augusta, Georgia significantly alleviated that problem by allocating project funds to provide transportation for patients who lived within 100 miles of Augusta to get to and from prenatal care visits and delivery.[4]

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1. 53:38
2. 35:81
3. 21:34
4. 14:428

G. There are Excellent Models for Providing Effective, Comprehensive Prenatal Care to Low-Income, Minority Women

The success stories of programs across the country which have effectively provided comprehensive prenatal care to low-income women are legion. Petitioners have selected some to be told; together, they address the diversity of cultural, socio-economic and geographic factors which must be taken into account when designing a prenatal service which can reach poor, pregnant women and significantly reduce the incidence of low birth weight.

Obstetrical Access Pilot Project

The Obstetrical Access (OB Access) Pilot Project in California was a legislative response to the diminishing numbers of physicians willing to accept Medi-Cal patients and to the documented inability of many low income women to obtain prenatal care, whether or not they were eligible for Medi-Cal.[1] Launched in 1979, OB Access combined funding from Medicaid and Title V to award existing community and county clinics' funds for comprehensive community-based services. In its first three years, OB Access has provided prenatal, delivery and postpartum services to nearly 7,000 women in thirteen underserved counties in both rural and urban areas of California.

In San Diego, for example, a consortium of eleven community clinics, the U.S.C. San Diego Hospital, and the San Diego Department of Public Health Services became the OB Access program which by 1981, was seeing nearly 1500 women each year.[1]

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[1] 91

Ten midwives provide routine prenatal care at the various clinic sites. Infant care pediatric clinics are conducted every week. Administrator Ann Bush described the program:

> "At the midwife-run clinics we provide nutritional assessment and counseling of all our patients, psychological counseling ... and extensive health education .... About 60% of the total patient load is Spanish-speaking, another 10% is Indochinese . . . . Almost all of the staff dealing directly with the patients are bilingual. ... When the patient comes in to deliver at University Hospital, she has the option of having her baby in an alternative birth center setting or the labor rooms .... About 80% of our patients are delivered by the midwives."[2]

The prenatal coordinator of one participating clinic described the services provided:

> "Nutrition is really stressed and reinforced ... with the WIC program. Breastfeeding is stressed and reinforced by the home visits of our pediatric nurse. Prenatal care is ... individualized. The health educators see people on an individual basis. We have the LaMaze classes available. They are part of the package."[3]

The OB Access Project also covers a 10,000 square miles, three-county area in rural Northern California. A sizeable number of patients are migrant or undocumented workers. Dr. Thomas Dodson, director of both the area's OB Access and WIC programs, notes that the project provides whatever is necessary for low-risk, no-risk, or high-risk mothers and infants.

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1. 91:128-129
2. 19:128-129
3. 70:130:131

> "We are finding that the earlier we get them . . . into the program, we are having much healthier babies . . . much healthier mothers. Currently . . . any OB Access mother . . . is automatically put on the WIC program . . . We cover all the aspects of perinatal development . . . the whole concept of birthing from conception through to birth. . . . We urge and encourage the fathers to be there. . . . I think it's indicative that we have a waiting list . . . As word of the program gets out . . . we are finding that our program is being somewhat overwhelmed by the response."[1]

Statewide results of the first year of OB Access were overwhelmingly favorable.[2] Low birth weight rates were half those of comparable Medi-Cal patients, and 86.2% of the women began prenatal care in the first two trimesters. In previously underserved areas, a high percentage of low income women received a full package of services. Such positive results provide strong evidence that comprehensive, integrated care is far more effective in reducing low birth weight than the typical Medicaid approach.

Su Clinica Familiar[3]

An excellent model for serving the Hispanic maternity population is a nurse midwifery service established in 1972, Su Clinica Familiar in the Texas Rio Grande Valley. Within its

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1. 41:34-35
2. 91:2
3 100:25-29

first three years, Su Clinica midwives were delivering nearly 80% of the births in the entire county. Su Clinica's quality prenatal care has lowered toxemia to only a few cases (2.9%) and reduced low birth weight, which is substantially less frequent than the rate for Texas and the country as a whole.

Family-centered comprehensive care is provided from pregnancy through delivery and into the first few weeks after birth. All family members are encouraged to stay with the woman while she is in labor, along with a nurse or nurse midwife who is in constant attendance.

> "The support of loved ones during the work of labor and in the face of intense physical readjustment cannot be measured. . . . Every effort is made to eradicate fear which plagues many laboring women who are left alone . . . . Our nurse midwives . . . listen to the repeated testimonies of mothers saying that the best alleviation of pain in labor comes from being attended by persons who show personal interest and give them constant support."

Upon discharge, a nurse or nurse-midwife makes two follow-up home visits to ensure all is well and to answer any questions. Of 753 live births at Su Clinica between 1972 and 1976, 98.7% of the mothers and infants were visited in their homes following delivery. Migrant workers who left the area shortly after the birth were referred to other migrant health clinics for continuity of postpartum and neonatal care.

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Lincoln Medical Center Teen Pregnancy Clinic[1]

In the South Bronx, Lincoln Medical Center's nurse midwifery service established a special evening clinic for teenagers in 1975. The Center addressed the special needs of pregnant teens, including providing clinic access during non-school hours. The opening of the special evening clinics was announced to this low income community (70% Hispanic, 28% Black) through handouts at local high schools and via the local newspapers, radio and television stations.

Each prenatal session commenced with a half-hour class for the patients, their family and friends on subjects including nutrition, labor and birth, the physical care and mental stimulation of the newborn, and family planning. Health education materials in Spanish and English included such practical topics as "Good Foods for Pregnancy and Breastfeeding", "Lovemaking in Pregnancy" and "Heartburn".

The program became so popular that registration had to be limited to adolescents 17 years or younger. Among the 204 teens cared for in the first two years of the program, the low incidence of toxemia (4.7%), LBW rate (6.3%), and high number of prenatal visits (93% had six or more) attest to the success of this approach with teenagers.

Booth Maternity Center Clinic for Pregnant Teens[2]

Convinced that individualized, comprehensive care would reduce the maternal and infant complications often found in pregnant teens, the Booth Maternity Center in Philadelphia instituted a special program in 1979 for teens, who comprise 8% of the Center's 1200 births each year.

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[1] 44:27-32
[2] 37:68-71

A nurse midwife follows each patient through pregnancy and delivery. Group sessions cover such topics as nutrition, fetal development, labor and delivery, parenting, and family planning. If, however, a teen has a problem or question, addressing the immediate concern automatically takes precedence over the scheduled discussion. Role playing and films are used to engage interest in abstract issues, such as how a support person can help to ease labor. At the sessions,

> " . . . pregnant teens are encouraged to bring along a special friend or relative who will become a labor coach or support person during labor and delivery. At first, the pregnant teen may react to the idea of a support person with resistance and embarrassment ('I don't want anybody to see me go through all that'). Nonetheless, by the time of delivery, every teen in our program has a support person."

A support person present often means a shorter labor and a decreased need for drugs and other interventions. Involving a family member helps alleviate family stress due to the pregnancy and fosters interaction with other parents of pregnant teens. And, every effort is made to involve the father of the baby in the labor and delivery to enhance bonding between him and the

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newborn.

This group of teens was compared to other teens at Booth who were not in the special program. Both groups had nearly the same distribution of prenatal problems, but the special program participants made significantly more prenatal visits, had fewer complications in labor and delivery, shorter labors and none required general anesthesia or forceps. They also had lower rates of maternal and neonatal morbidity, higher rates of postpartum checkups, greater acceptance of birth control and higher rates of breastfeeding. The number of premature births was not significantly different (4% v. 6%), but both fell way below the national average of 14% premature births born to teenage mothers, thus attesting to the excellent care Booth provides for all of its teenagers.

Oakland Perinatal Health Project[1]

In 1978, Governor Jerry Brown responded to alarming rates of low birth weight and infant mortality in the low-income Black and Hispanic communities of Alameda County by directing the California State Department of Health Services to initiate the Oakland Perinatal Health Project (OPHP). The Project funds a full range of prenatal, support and pediatric services through ten county and community clinics. Nutrition services at the clinics are tightly coordinated with the county WIC program. OPHP also has developed educational materials, conducts training, and has

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launched a local media program.

By 1982, over 1,700 women had enrolled in one of the OPHP clinics for prenatal care, including 24.9% Black, 24.8% Hispanic, 5.4% Native American, 15.6% Southeast Asian, and 21.2% white patients.

OPHP's midwifery program and alternative birthing rooms at the county hospital caught on quickly. This service has been credited with increasing the number of deliveries at the county hospital from 560 in 1978[1] to nearly 1,000 in 1983.[2]

> "I received my prenatal care at the midwifery health clinic and was referred to them because of two miscarriages I had earlier.. I chose to go through the midwives because of different people's experiences with them. I had a very close relationship. Each time I went in, they told me what was happening ... where the baby's head was, how much I weighed, what I should do and what I shouldn't do. And one of them was with me during my labor and the moment I went into the hospital until the delivery and afterwards ... I had three older children with me in there during the delivery along with my sister and a friend and my husband, and the experience was incredible." [3]

Sixty-one percent of the OPHP clients were Medi-Cal or had eligibility confirmation pending, 17.4% were uninsured, and 9% had private insurance. Some of the privately insured women selected OPHP for the nurse midwives and comprehensive care not generally found in the private sector. One woman explained:

> "The main reason I went to a midwife [was] I tried two private doctors and they didn't give me the time. This is my first child and I didn't know anything about having a baby. So they were very helpful. They showed me different books on how to

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[1] 2:60
[2] 116:128-129
[3] 4:29-30

> deliver. I wanted to breastfeed my baby. They showed me how to do that ... [When] I had problems trying to breastfeed .... they were there .... They came over to the house .... to show me. A private doctor wouldn't do that."[1]

And another said:

> "I have private insurance, but I chose to go to the East Oakland Family Health Center because [of] ... the midwifery services ... private physicians ... [and] the different programs they had to offer. I can't stress enough the importance of a woman having these choices. ... And that's why I received my care there instead of going to a private doctor's office."[2]

OPHP successfully reduced LBW among its socioeconomically high-risk population. Now in its fifth year, OPHP is the first demonstration project in California to receive funding beyond the usual three-year cycle.

Nurse Midwife Programs

Comprehensive prenatal care and nurse-midwives frequently go hand-in-hand. Many industrialized nations with infant mortality rates far below the U.S.'s rate rely primarily on midwives to handle normal pregnancies and deliveries and only refer complex cases to specialist obstetricians whose training emphasizes management of high risk women. In Norway, nearly 96% of pregnant women receive care and delivery from midwives; in England, 70%.[3]

In the United States, nurse midwives have faced serious opposition since the turn of the century resulting from professional power struggles and major social, cultural and economic changes in the provision of maternity care,[1] especially the rise of hospital-based obstetrics. Nonetheless, during the last twenty years, many consumers have questioned modern birth practices as unduly interventionist, impersonal and expensive, and have increased their demands for midwives. Yet, even though women of all income levels and ethnic backgrounds, have enthusiastically accepted nurse-midwives,[2] they still face considerable obstacles to practice from physicians and hospitals, particularly in the private sector.

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[1] 132A:31-32
[2] 52b:30-31
[3] 56:11

Where permitted to practice, professionally trained midwives have maintained a longstanding tradition in this country of providing low cost, quality care to low income pregnant women.

Frontier Nursing Service [3]

In 1925, English-trained Mary Breckenridge opened the Frontier Nursing Service (FNS) in eastern Kentucky to bring primary health care to impoverished Appalachian women. In its first seven years, the FNS provided prenatal care and delivery to 1000 women and so dramatically reduced maternal and infant deaths in the area that the Metropolitan Life Insurance Company declared in 1932 that "if such services were available to the women of the country generally, there would be a saving of 10,000 mothers' lives a year in the U.S., there would be 30,000 less stillbirths and 30,000 more children alive at the end of the first month of life."[1]

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[1] 21:161
[2] 151:4-5; 129:2; 40:85
[3] 15:14-17

In 1970, the service was expanded to include entire families. Today, FNS is a network of rural nursing outposts, each linked to a nearby primary health care center. Each outpost is primarily staffed by a nurse-midwife who provides prenatal and postpartum care and, when necessary, home delivery.[2]

Maternity Center Association

The Maternity Center Association began providing maternity care to poverty stricken immigrants living in New York City tenements in 1914, and opened a nurse midwifery service and training program which continues today. Between 1931 and 1951, 5,765 women received care at MCA. Attended by nurse-midwives, 87% gave birth at home.[3] Maternal mortality was .86/1000 live births,[4] neonatal deaths over these years averaged 15/1000, far below New York City rates of 28/1000 in 1931 and 18.4 in 1951.[5] In response to consumer demands, MCA established the Childbearing Center in 1975, which provides a safe alternative for families desiring a healthy birth in a non-

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1. 134:262
2. 69a:4-12
3. 82:178-184; 49:395-402
4. 82:178-184
5. 134:265

hospital setting. The Childbearing Center is a model for care that could be replicated in rural and underserved areas of the country.[1]

Madera County Nurse Midwifery Project

In 1960, the state of California funded a three-year demonstration project utilizing nurse-midwives at the obstetrically understaffed Madera County Hospital to provide prenatal care and delivery for medically indigent farmworkers. Before the project began, more than half the mothers had inadequate or no prenatal care and about one-fifth of the hospital deliveries were unattended by physicians.[2] Special waivers were obtained to employ two nurse-midwives (nurse-midwives were not legally licensed to practice in California until 1974). The midwives handled all normal cases and performed 78% of the hospital deliveries,[3] assisted by staff and consulting physicians when complications arose.

Beyond routine care, the midwives overcame "many cultural and educational barriers to motivate many more women to seek prenatal care".[4] Prior to the midwifery program, 26% of the mothers had six or more prenatal visits compared to 35% once the program opened its doors.[5] Those beginning prenatal care in the first trimester doubled from five to ten percent.[6]

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1. 48:4
2. 99:309
3. 85:51
4. 85:51
5. 99:311
6. 99:311

Mothers were attended throughout the course of labor and the numbers of women returning for postpartum examinations six weeks after delivery rose from 37% prior to the project to 47%.[1]

Even more striking results are apparent when comparing rates of low birth weight and deaths before, during and after the program. During the project years from 1960-1963, low birth weight rates plummeted from 11% to 6.6%; two years after the project ended, LBW rose to 9.8%.[2] Neonatal deaths dropped from 23.9/1000 live births in 1959 to 10.3 in 1961.[3] In the three years following the departure of the midwives, neonatal mortality skyrocketed to 32.1/1000 live births, nearly one-third higher than pre-project deaths, and a tripling of project neonatal mortality. Thus, the current neonatal mortality goal of the American College of Obstetricians and Gynecologists, 10/1000 live births, was achieved twenty years ago by two midwives who provided primary care and sensitive attention to women's needs for a very high risk population.[4] Analysts of the Madera project concluded that after its closing, the decreased availability and lower quality of prenatal and delivery services accounted for the increases in LBW and neonatal mortality and the drop in prenatal care visits after the program ended.[5]

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[1] 99:311
[2] 85:53
[3] 99:312
[4] 21:166
[5] 85:57

> "The main problem, therefore, is not that we lack effective preventive care techniques to assist infants, young children and pregnant women, but that techniques of known effectiveness still have not been applied widely enough." [1]

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[1] 138:23

VI. PROVIDING ADEQUATE PREVENTIVE CARE IS COST-EFFECTIVE

A. Introduction

As discussed in the previous section, various studies have clearly established the relationship between inadequate prenatal care and higher incidences of low birthweight infants.* Further, it is well-documented that low birthweight infants are significantly more likely to develop permanent disabilities such as cerebral palsy, mental retardation, learning problems, and hearing and visual disturbances.[1] Generally, this country's response to the problem of low birthweight infants has been to devote massive amounts of energy and resources to developing highly sophisticated and technological methods of saving the lives of these infants.[2] While such intervention has proven highly successful in reducing the infant mortality rates of very low birthweight babies,[3] it has also proven to be extremely costly.[4] More importantly, this approach has been aimed primarily at providing a solution to the problem -- the survival of low birthweight infants -- rather than with prevention of the problem -- preventing the incidence of such births.

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* _See_ discussion at Section V, _supra_.

[1] 138
[2] 142
[3] 17:5
[4] 17

This section analyzes the costs and savings of providing adequate prenatal care to lower the incidence of low birthweight infants, as compared to the costs incurred in providing neonatal intensive care (NICU) and rehospitalization, the two most frequent and expensive types of care associated with low birthweight. While many programs have documented that increased levels of prenatal services have resulted in improved pregnancy outcomes,* none have attempted to quantify the costs and savings to the federal government that would accrue by providing prenatal care.** This petition does precisely that, using the most conservative figures and estimates available.

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* See discussion at Section V, supra.

** Several articles have computed, simplistically, general savings to be gained by providing prenatal care to prevent the incidence of low birthweight infants. For example, one has stated that if only five women not receiving prenatal care give birth to a moderately ill premature, a very conservative estimate of the hospital cost for the five prematures would be $150,000 (not including post-hospitalization costs). However, if that $150,000 had been allocated for prenatal care, 149 women could have received prenatal care to avoid those hospital costs. M.A. Curry, Preliminary Report on a Survey of the Access to Perinatal Care and the Incidence of Perinatal Morbidity in Oregon 11 (1983). This estimate, however, fails to provide evidence that caring for 149 women would save the five prematures.

Another report estimated that for 3700 women who gave birth to low birthweight infants in California, an estimated $6-$7 million would have been saved in neonatal intensive care costs had they received prenatal care. Such care for the same number of women would have cost only $2,812,000. A Report to the Legislature, Perinatal Care Plan 4, Maternal and Child Health Branch, Department of Health Services, California (1982).
(footnoted continued on next page)

B. General Methodology

Generally, the cost-effective analysis in this petition surveys various health care literature and studies. In particular, the analysis relies, to a large extent, on a study conducted by Carol C. Korenbrot* on the expected costs and savings of comprehensive prenatal care to the State of California.** The study focused on the findings and conclusions of the Obstetrical Access Pilot Project, "OB Access Project", which was funded from July 1, 1979 through June 30, 1982 and

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(footnote cont'd.)

Further, a doctor is quoted as saying "Prenatal care is cheap when compared to the costs to care for an infant born in the high risk group. Care for an average premature infant that lives costs $100,000 and $60,000 for one that dies. The cost to keep an infant on a respirator for 18 months recently came to $1.5 million." G. Dallek, America's Widening Infant Death Gap, Health and Medicine 3 (1982), quoting Declaration of Dr. Sylvia Bean, filed in C.H.A. v. Bd. of Supervisors, L.A. Superior Ct., C360-546. Another doctor estimated that the cost per premature infant averages $79,418 and that every 100 women denied prenatal care will cost L.A. County $397,090 in avoidable neonatal intensive care costs. Id., citing Testimony presented by James F. Padbury, M.D. before the Commission on the Status of Women, "Perinatal Health of Los Angeles County's Indigent Population---A Fiscal and Political Cost-Benefit Analysis", May 19, 1982.

* Ph.D., Department of Obstetrics, Gynecology and Reproductive Medicine and the Institute for Health Policy Studies, University of California, San Francisco.

** Korenbrot, C., Comprehensive Prenatal Care as MediCal Benefit, Expected Costs and Savings, Contract Report to Maternal and Child Health, Department of Health Services, California (1982) [hereinafter Korenbrot I]. Certain parts of the study were updated in C. Korenbrot, Additional Costs to the State for Maternal and Child Health with Public Health Block Grants (1983) [hereinafter Korenbrot II].

registered a total of nearly 7,000 women.* The OB Access Project was designed to improve MediCal** maternal medical care in three ways: (1) increasing access to OB Access services for MediCal and low-income pregnant women in project areas; (2) assessing the quality of maternal MediCal care by review of the amount of services provided and health outcomes of patients of individual providers; and (3) to determine the impact of providing comprehensive prenatal care to project registrants.

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* The OB Access Project was formulated in response to major gaps in the availability and extent of perinatal services in California, particularly in certain geographic areas and ethnic groups. Two major problems came to the attention of state medical and health officials: (1) the inability to render adequate care at the low prevailing rate of MediCal reimbursement; and (2) MediCal eligible and low-income women were experiencing severe problems in access to physicians, particularly physicians with formal training in obstetrics.

In order to implement the project, waivers were solicited from the Department of Health and Human Services, Health Care Financing Administration. The waivers were granted under section 1115(a) of the Social Security Act for a period of three years ending June 30, 1982 (renewable annually).

In most cases the sites selected were expansions of existing community clinics and county health departments. No private providers were willing to participate as primary contractors, although they did participate as subcontractors of medical care services. This arrangement resulted in the active participation of several excellent private physicians and supervised nurse-midwives in areas where no prenatal care services had existed for MediCal and other low-income women. Preliminary Evaluation of the Obstetrical Access Pilot Project July 1979-June 1980 5-7 Maternal and Child Health Branch, Department of Health Services, California (1982).

** "MediCal" is the California equivalent of the federal Medicaid program, and means the California Medical Assistance Program. Calif. Welf. & I. Code § 14063. Under the MediCal program, federal funds match state expenditures for medical care provided under the state plan. The federal share in California is 50%.

It was the last part of the project that was under consideration in Korenbrot's analysis. That analysis was designed to determine expected MediCal savings through the provisions of comprehensive prenatal care to MediCal recipients. In the Korenbrot analysis, the prenatal care presently provided to MediCal low-income women is referred to as "present prenatal care." Korenbrot calculated the costs of present prenatal care and compared them to the cost of providing "comprehensive prenatal care".* The difference constituted the total expected cost to the state of providing complete, comprehensive care through MediCal.

Korenbrot then calculated the total expected costs to the state of caring for low birthweight infants in neonatal intensive care and in rehospitalization. In both cases, the calculations are made according to birthweight. Cost increases as birthweight decreases,** as does the frequency with which infants of different birthweights require rehospitalization and neonatal intensive care. Using the Cleveland Maternal Infant Care Study[1] as the basis for the most optimal documented effect of such a program upon birthweight, the investigation determined that a benefit-to-cost ratio of approximately 2 to 1* would accrue based upon reduction of needs for neonatal intensive care and infant rehospitalization through the first year of life alone.**

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* _See_ discussion at 103-105, _infra_.

** _See_ 17:5 and 94:992,998, _infra_, and discussion, p. 125.

[1] 131:150

The implications of this study are profound and provide solid evidence that prenatal care is indeed cost-effective. The analysis herein, which calculates current costs to the federal government, closely follows the Korenbrot technique. Like MediCal, the federal Medicaid program provides prenatal care to low-income Medicaid-eligible pregnant women ("present prenatal care"). The difference between the cost of providing present prenatal care and the cost of providing comprehensive prenatal care,*** multiplied by the number of Medicaid-eligible pregnant women constitutes the expected cost to the federal government for those women. The expected cost to the federal government of expanding Medicaid coverage for comprehensive prenatal care to other needy women is computed by multiplying the cost of providing comprehensive prenatal care by the number of Medicaid-ineligibles, low-income women needing such coverage. The total expected cost to the government is the sum of the costs of providing comprehensive care to both Medicaid-eligible women and Medicaid ineligibles.

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* Preliminary data show that OB Access patients had half the incidence of low birthweight compared to a matched group of Medi-Cal patients (3.9% v. 7.3%). Preliminary Evaluation at 52.

** Korenbrot I, supra, at 1, 12. The figures in Korenbrot I and used herein are preliminary and are based on a range of expected costs and savings predicted by calculation, rather than on actual, observed figures. At present, the actual figures are being determined by officials for the OB Access Project. Preliminary data indicate that the actual savings to the state are in fact greater than predicted in Korenbrot's analysis.

*** The cost of "present prenatal care" and "comprehensive prenatal care" are extracted from Korenbrot I, which refers specifically to "MediCal dollars." Korenbrot I at Table 2. Since the federal share in California is 50%, the federal costs are 50% of the total costs used in Korenbrot's study.

Under the Medical Assistance Program (Medicaid), Title XIX, Social Security Act, as amended; P.L. 89-97, 90-248, 91-56; 42 U.S.C. 1396 et seq.; P.L. 92-223, 92-603, 93-66 and 93-233, states are required to provide certain types of services for the medically needy, for which federal financial participation is available. The federal share ranges from 50% to 78%. Catalog of Federal Domestic Assistance 234, Office of Management and Budget (1983).

Costs of providing comprehensive prenatal care are then compared to the two most frequent types of current costs incurred in treating low birthweight infants -- neonatal intensive care[1] and rehospitalization.[2] It is estimated that 15%* of the Medicaid-eligible women receiving only present prenatal care will give birth to low birthweight infants, and that 20% of Medicaid ineligibles will deliver low birthweight infants. The total current cost to the federal government for providing care to low birthweight infants is computed by multiplying the number of low birthweight infants by the frequency of rehospitalization and NICU and by the cost of providing those services.

Finally, the initial savings to the government in providing care to reduce the number of low birthweight infants after comprehensive prenatal care is provided is computed by the same formula. Only this time the number of low birthweight infants will be much smaller since the estimates of low birthweight infants will be less; *i.e.*, 5.5%* for Medicaid eligibles and 7%* for Medicaid ineligibles. Comparing the two costs, a tremendous savings is to be gained by reducing the incidence of low birthweight infants. Moreover, even after subtracting the costs of providing comprehensive prenatal care, the real dollar savings to the government is great. Further, the savings are conservative estimates because they do not include long-term costs.

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[1] 17
[2] 94:991
* See explanatory footnote, p. 112, double asterick

C. The Components and Costs of Prenatal Care

Comprehensive prenatal care programs were founded on the premise that the high rate of adverse pregnancy outcomes among economically disadvantaged women would be diminished by combining medical care with social, nutritional and educational services.[1] Thus, comprehensive prenatal care provides basic medical care, health education, nutrition counseling and social work counseling.[2] The components of prenatal care vary widely from state to state, hospital to hospital, and in particular they vary depending upon the needs of each individual woman. As discussed in Section V, *supra*, however, there are certain basic components of prenatal care that are essential to improving pregnancy outcome. As defined in the OB Access project and for purposes of this petition, "comprehensive prenatal care" includes routine prenatal, delivery and postpartum care (11 recommended examinations) and routine laboratory tests (22 individual

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1. 98:1
2. 98

* See explanatory footnotes, p. 119.

tests, generally blood and urine analyses), a Psychosocial Assessment, a Nutrition Assessment, and 16 hours of Perinatal Education, as well as an initial outpatient well-baby examination. The assessments determine what interventions are indicated to reduce psychosocial nutritional or educational risks and these interventions are then 'treated' with counseling.*

Under Medicaid, state governments presently pay for prenatal care to pregnant women which differs from state to state. At the threshold, then, it is necessary to compare present prenatal care costs and comprehensive prenatal care costs to show the additional costs of adding comprehensive prenatal care to current Medicaid benefits. For example, in California, "present prenatal care", as currently provided by Medi-Cal and as defined in the Korenbrot study, includes all services in the comprehensive prenatal care package (defined above), except "assessments", 16 hours of perinatal education and vitamins. The following analysis utilizes this definition and the costs of present prenatal care as computed in Korenbrot's study.

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* For example, the OB Access Project provided health education services for "high risk behavior" such as smoking, drug abuse, alcohol abuse and non-compliance with medical advice/regimen during pregnancy to modify or change such behavior by education. Similarly, education about "high risk medical conditions" such as diabetes, blood disorders, kidney problems or second pregnancy within one year was provided by certified medical professionals. Psychosocial services consisted primarily of individual and/or group counseling or home visits to identify and treat psychosocial problems such as ambivalence or rejection of the pregnancy, spousal abuse or non-support, depression, psychotic thinking or behavior, extreme anxieties regarding labor and delivery (cesarean section, use of forceps, death, pain, baby may be abnormal). Finally, the nutritional component offered dietary, biochemical, and physical-medical education to treat mineral, protein, vitamin and other deficiencies, to prevent excessive junk food, caffeine, sugar, or fat intakes, and to treat persistent diarrhea, constipation, nausea or vomiting. Preliminary Evaluation of the OB Access Project at Appendix 3.

The costs of present prenatal care to MediCal recipients were not available directly but were estimated in two ways. A low estimate was obtained by using the "global fee" for prenatal, delivery and postnatal care of the mother, and routine care of the newborn (excluding inpatient hospital costs).[1] The total fee for a vaginal delivery with present prenatal care based on the global fee is $722.43 (1982 dollars). See Table 1 at 107. A similar estimate for a Cesarean Section with present prenatal care is $1,148.94 (including the prenatal lab fees and routine outpatient newborn examination) (1982 dollars).

A second way of estimating the costs was based on the fees-for-service for the services that should be included in present prenatal care (i.e., basic comprehensive prenatal care package excluding assessments and vitamins).[2] The expected costs shown in column 2 of Table 1 represent a high estimate of expected MediCal costs.

Comparable costs for Comprehensive Prenatal Care in the OB Access Project were higher (Table 1, columns 3 and 4). By adding all fees-for-service for the entire basic package,

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1. 81:6-7
2. 81:7

the maximum cost of a vaginal delivery is $1,111.07, including interventions or "assessments" (valued at a maximum cost of $146.41, 1982 dollars) and excluding inpatient hospital costs (1982 dollars). In computing an expected estimate for a Cesarean Section in the same way as for Present Prenatal Care above, the corresponding figure for Comprehensive Prenatal Care is $1571.83. Again, the maximum expected MediCal costs for care of prenatal, delivery and postnatal periods are shown in Table 1 under "Expected Costs" (1982 dollars).

The expected costs to the federal government of providing "comprehensive prenatal care" to pregnant women eligible for Medicaid can therefore be estimated using the figures in the Korenbrot study. Using the figures in the column entitled "Expected Costs", the additional cost to the federal government of providing comprehensive care ranges between $144.79 (50% x ($1076 - $786.41)] (low estimate in 1982 dollars) and $171.19 [50% x ($1188.01 - $845.63)] (high estimate in 1982 dollars). These figures will increase or decrease depending, of course, on the types and quantities of care currently provided by the different states under Medicaid already. Assuming that the average expected cost to the federal government is $157.99 [($171.19 + $144.79) x 1/2], and assuming that there exists approximately 396,000 women eligible for prenatal care services

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Table 1.

MediCal Reimbursement* of
Costs of Prenatal and Delivery Care
(1982 Dollars)**

	With Present Prenatal Care		With Comprehensive Prenatal Care	
	Based on Global Fee***	Based on Fees-for-services****	Based on Final Claims Claims†	Based on Fees-for Services††
Vaginal Delivery	$722.43	$776.51	$999.67	$1111.07
Cesarean Section†††	$1148.94	$1237.28	$1460.44	$1571.83
Cesarean Section Rate††††	15%	15%	16.7%	16.7%
Expected Costs	$786.41	$845.63	$1076.00	$1188.01

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* Includes prenatal, delivery and routine postpartum obstetric care. Korenbrot I, supra at 22.

** All 1980 dollar figures in Korenbrot I were inflated at the medical cost inflation rate for 1981-82 of 10% per year to 1982 dollars.

*** Package rate, (8 RVS Units) with August 1980 conversion factor ($60.08/RVS Unit). 1980 was the reference year because it was the first year of the OB Acces Project registrants. But see note 25, supra. Laboratory fees and a routine outpatient newborn care examination were added to make the package comparable to the OB Access Basic Package, Table 1. Korenbrot I at 22.

**** Present Prenatal Care includes all services in Basic Package, Table 1, except "assessments" and vitamins. Comprehensive Care includes entire Basic Package.

† Not all participants in the OB Access Project utilized all comprehensive services available. During the first contract year (1980), the reported utilization rates for the Psychosocial Assessment was 84.1%, for the Nutrition Assessment, 85.2%, for the Health Education assessment 86.8%, for the Birth Edu-

(footnotes continued on next page)

under Medicaid,* the total expected additional cost to the federal government for providing comprehensive prenatal care to Medicaid-eligible women is $62,564,040.00.**

(cont'd from previous page)

cation Assessment, 72.2%. The figures in this column are thus based on observed average utilization of "assessments" with 93% of final claims for 917 registrants of the first contract year. Korenbrot I at 8, 22.

†† *See* note **** at 107 *supra*.

††† Calculated by subtracting Vaginal Delivery (4 RVS Units) from Vaginal Delivery Care costs and adding (10 RVS Units for) Cesarean Section. Korenbrot I at 22.

†††† Observed rate: 1979 MediCal Deliveries (Data Matters, #81-06011, June 1981); 1980 OB Access Pilot Project, first contract year, based on 93% final claims of 917 registrants. *Id.* The rates here are also consistent with the national proportion of cesarean rates to all deliveries, which was 15% in 1978. *Better Health* at 15.

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* Of the 3.3 million patients hospitalized for deliveries in the United States in 1977, Medicaid was expected to pay for 12 percent. *Better Health for Our Children: A National Strategy, The Report of the Select Panel for the Promotion of Child Health: 1980* 14, U.S. Department of Health and Human Services (1980). This figure is, of course, underrepresentative in that it has increased since 1977; it does not include those women who were not reported to be within the Medicaid system because of various state or local practices of reporting; and of the 396,000, some women will get prenatal care, others will not because even despite the availability of Medicaid, health care patterns in seeking care will not be changed. *Better Management* at 108.

The figure is overrepresentative of prenatal care requirements to the degree that it includes twins or triplets and it also includes women who have two children within 12 months. These occurrences, however, are still very rare.

** Average expected cost of providing comprehensive prenatal care multiplied by the number of women eligible for prenatal care services under Medicaid.

The number of women receiving early, comprehensive prenatal care would be higher if the federal government expanded Medicaid coverage to other groups of women most in need of such care ("Medicaid ineligibles"). The only existing official estimate of women needing Medicaid coverage is 220,000.*

The cost of providing comprehensive prenatal care through Medicaid to these additional 220,000 women ranges from $538 (50% x $1076) to $594 (50% x $1188.01), with an average cost of $566 per recipient.** Thus, the total expected cost to the federal government for providing comprehensive prenatal care to these women is $124,520,000.* The total expected cost to the government for providing comprehensive prenatal care to Medicaid eligibles and ineligibles is $187,084,040.**

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* H.R. Rep. No. 568, 96th Cong., 1st sess. 85 (1979). This figure is estimated from a simulation of the medicaid eligibility rules using information on income and family characteristics from the 1976 Survey of Income and Education, and was used in a cost estimate of H.R. 4962, the Child Health Assurance Act of 1979. Because the estimates were based on 1976 data, this figure is a very low estimate of the number of ineligibles.

The figure is not broken down into any specific categories of needy women. However, there are three general categories, including first-time pregnancies. Women pregnant for the first time are not universally eligible for AFDC or Medicaid's medically needy program because they have no dependent children. In 1978, 19 states had no Medicaid coverage for prenatal care for these women; in 30 states and the District of Columbia they were eligible if they met criteria of need; Arizona had no Medicaid program. Better Health at 9. The second category of poor pregnant women in need of Medicaid coverage are those who meet a state's income and resource standards and are now excluded from the program because, although impoverished, they are part of two-parent families. Children's Defense Budget at 44. Finally, the third category is composed of the women who have incomes that exceed the maximum for eligibility for AFDC but are insufficient to pay for medical care. Better Management at 104.

** The full cost of providing care is used here, and not the difference between present prenatal care and comprehensive prenatal costs, since these women are not now eligible under Medicaid to receive present prenatal care.

D. The Costs of Caring for Low Birthweight Infants

1. Neonatal Intensive Care

One of the primary medical expenses associated with caring for low birthweight infants is neonatal intensive care.[1] Neonatal intensive care is defined by the American Academy of Pediatrics as the constant and continuous care of the critically ill newborn.[2] This type of care consists largely of one-to-one, specialized 24-hour nursing care, respirators, blood-gas and other diagnostic and therapeutic procedures to compensate for the lack of full development of the infant.[3]

In the United States, approximately 6% of all live births (60/1000) go to intensive care (about 200,000 admissions annually).*** Nearly one half of those requiring neonatal intensive care, or 100,000 are due to complications associated with low birthweight.[4] The costs of neonatal intensive care are great. One study has concluded that among patients with high hospitalization cost ($4,000 or more in one year), neonatal cases were by far the most expensive, averaging over $20,000 each.[1] Various reports of neonatal intensive care costs range from $1,800 to $40,000 per patient.[2] Neonatal intensive care costs vary greatly according to a variety of factors, including low birthweight. Studies have shown that as birthweight decreases, cost increases.[3] Average expenditures in 1983 per patient are estimated to be about $13,400.* The total annual costs in the United States for low birthweight-related neonatal intensive care is therefore approximately $2.6 billion.** For low birthweight-related neonatal intensive care, costs are one-half that, or $1.3 billion.***

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* Average cost of comprehensive prenatal care multiplied by number of women requiring Medicaid coverage.

** Total expected cost of providing comprehensive prenatal care to Medicaid-eligible women added to total expected cost of providing comprehensive prenatal care to women requiring Medicaid coverage.

*** Budetti at 7. This is an estimate of neonatal intensive care units admissions available in the literature and from NICUs. No national data exist that describe the amount of neonatal intensive care currently being delivered in the U.S.

[1] 17:11

[2] 17:7

[3] 17:7

[4] 16

The federal share of providing neonatal intensive care is difficult to ascertain, since there are only minimal data regarding how much of the cost is paid for by Medicaid.[4] It is known, however, that approximately 396,000 women per year obtain present prenatal care through Medicaid.* From this number of women, it is conservatively estimated that approximately 15%**or 59,400 will give birth to low birthweight infants.[51] It is also estimated that of the 220,000 Medicaid ineligibles, 180,000 will be covered by Medicaid once they give birth***, and 20% or 36,000 will deliver low birthweight infants.**** Of the 59,400, approximately 25% or 14,850 will be very low birthweight infants (1500 gms or less); the remainder, 44,550 will be low birthweight infants weighing 1501 to 2500 grams. Of the 36,000 ineligibles, approximately 30% or 10,800 will be very low birthweight infants; the remainder, 25,200 will be low birthweight.*

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* Speech by Peter Budetti. _See also_ Budetti at 5 (estimated average expenditures per patient to be about $8,000 in 1978). The estimate cited in the text is an updated figure.

** Number of births (3.3 million) multiplied by percentage of all low birthweight births admitted to NICUs (0.06) multiplied by mean cost/patient ($13,400).

*** _See_ note **, _supra_.

[1] 17:19
[2] 17
[3] 17:5
[4] 17:23-27

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* See note *, at 108, and accompanying text.

** Since there are no data regarding the number of low-income women (both Medicaid eligible and Medicaid ineligible) who deliver low birthweight infants, the 15% figure was estimated from a review of the low birthweight rate of low-income women throughout the country. For instance,in the Cleveland study,the low birthweight rate was 14%. Sokol, et al. at 155. In Minnesota the rate was 13.9%. Berg, et al. at 33. In rural Georgia, 24%. Reid and Morris at 491. In New York City, 21.9%. Gold, et al at 1951. In the South Bronx, 18.1%. Doyle and Widhalm at 4. In California, 7.3%. Prel. Evaluation of the OB Access Project at 52. Thus, the 15% estimate is within the range of previously reported low birthweight rates among low-income women.

*** Of the total 220,000 Medicaid ineligibles, 60,000 are first-time pregnancies who will be covered by Medicaid once they deliver. See H.R. Rep. No. 568, 96th Cong., 1st sess. 86 (1979). Of the remaining 160,000, 80,000 will also be covered by Medicaid as "financially needy" children (commonly known as "Ribicoff" children after the Senate sponsor of the 1965 Medicaid amendment creating this eligibility category). Because the original 220,000 ineligibles in based on an estimate of those women whose incomes are less than 80% of the poverty level, id., 80,000 is a fair estimate of "Ribicoff" children, whose family incomes are between 40%-50% of the poverty level. Finally, the remaining 40,000 will be covered as "medically needy" children under the Medicaid program.

**** The 20% figure is estimated from 15%, see note **, supra, and increased to account for the fact that these women are low-income who receive little or no prenatal care (as compared to the Medicaid eligibles who receive present prenatal care) and who will therefore fare worse than those receiving such care.

Table 2 shows the current federal costs of neonatal intensive care for low-income, low birthweight infants.

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* Of the 3.3 million total births annually, 7% or 230,000 are low birthweight infants (2500 gms or less). National Center for Health Statistics, Monthly Vital Statistics Report, Final Natality Statistics, 1975-1980 HEW. 16% of those low birthweight infants are very low birthweight. That percentage is increased here to 25% for Medicaid eligibles and 30% for Medicaid ineligibles to account for the fact that the very low birthweight rate among Black, low-income women is two to three times the rate for whites, Budetti at 13, and the fact that the Medicaid ineligibles are at a higher risk of delivering very low birthweight infants because they receive little or virtually no prenatal care. Further, these percentages reflect a very small portion of the total group of eligibles and ineligibles.

Table 2.

Federal Costs of Neonatal Intensive Care of Low Birthweight Infants

Birthwgt. (gms)	Freq.* (%)	No. of LBW infants** (95,400)	Infants requiring NICU***	Cost/ infant† ($)	Total Cost†† ($)
≤1500	100	25,650	25,650	20,720	531,468,000
1501-2500	32.8	69,750	22,878	2,090	47,815,020
				TOTAL:	$579,283,020

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* This column represents the frequency with which infants in the various low birthweight categories require intensive care. The 32.8% figure constitutes a weighted average of the frequency percentages for birthweights 1501-2000 (85%) and 2001-1500 (21%). Korenbrot II at Appendix B.

** *See* discussion at 112-113, *supra*.

*** The figures in this column are obtained by multiplying the number of low birthweight infants by birthweight with the frequency percentage.

† Korenbrot II at Appendix B (1982 dollars). The $2090 figure is the average cost for those infants weighing 1501-2000 ($2560) and 2001-2500 ($1620). *Id*.

†† Number of infants multiplied by cost per infant.

2. Rehospitalization in the First Year of Life

Generally, the first year of life is an age when morbidity and medical use are high, and this is particularly true for low birthweight infants.[1] It is not surprising, then, that another major medical expense associated with caring for low birthweight infants is rehospitalization. "Rehospitalization," as used herein, is defined as one or more events of hospitalization of an infant during the first year, not including the hospitalization after birth before the infant went home for the first time.[2]

In a study of the rehospitalization of infants,** information on health problems, medical care utilization, and developmental status was obtained from a large random sample of 4,989 infants born to residents of eight regions during a six-month period in 1976.* Using these data, it was found that 9.1% of the total had been rehospitalized at least once during the first year.[3] This is within the range of previously reported values which may vary from 7.0% of infants of affluent families to 20.0% of those in disadvantaged settings.[1] Low birthweight infants were over twice as likely and very low birthweight infants 4.5 times as likely to be hospitalized as normal birthweight infants.[2] Further, the percentage rehospitalized increased with decreasing birthweight; 38.2% of infants, 1,500 grams or less experienced at least one hospitalization during the first year.[3] Low birthweight infants also accrued more hospital days.[4] Hospitalized infants with birth weights over 2,500 grams averaged 7.8 days in the hospital, but this figure increased to about 16 days for those 2,000 grams or less at birth.[5] Thus, although low birthweight infants accounted for 6.4% of surviving one year old infants, they accounted for 13.0% of those hospitalized and 20.0% of all hospital days among this group of infants.[6] See Table 3.

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* The eight regions, characterized by a wide spectrum of ethnic and sociodemographic variables and medical care environments, accounted for about 6% of the births in the U.S. They were: State of Arizona; 15 counties around Syracuse, in Upstate New York; upper west-side of Manahattan (Central Harlem, Washington Heights, Riverside); Dallas County; Cleveland and surrounding Cuyahoga County; three regions in Los Angeles County (Southeastern, Central and Coastal Regions and San Gabriel Valley).

** See 94:7 (the "McCormick study")

[1] 94:991
[2] 94:992
[3] 94:992

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1. See 94:998; 58:644; 1:425; 66:425
2. 94:992, 998
3. 94:992, 998
4. 94:992, 998
5. 94:992, 998
6. 94:992, 998

Table 3.

Percentage Rehospitalized, Average Days of Hospitalization for Low Birthweight Infants[1]

	Birth Weight				
	≤1500	1501-2000	2001-2500	≤2500	≥2500
Total: 4,989	259	660	2,260	3,179	1,777
% Rehospitalized at least once	38.2	21.0	16.2	19.0	8.4
% Rehospitalized who were rehospitalized more than once during first year	34.7	39.0	25.5	----	16.5

Reasons for rehospitalization were similar for all birth weight groups, and only a small set of conditions accounted for the majority of admissions.*

Using the average number of days for each infant rehospitalized by birthweight, the average cost per infant according to birthweight, and the total number of low birthweight infants delivered by both Medicaid eligibles and ineligibles,** the current costs to the federal government are calculated as follows:

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* The reasons for admission included congenital anomaly/developmental delay, lower respiratory and upper respiratory tracts, GI tract, accident/ingestions, and other infections. _Id_.

** _See_ discussion at 112-13, _supra_.

[1] 94:993 Table I

Table 4.

Federal Costs of Rehospitalization for Low Birthweight Infants

Birthwt. (gms)	ALOS* (days)	No. of infants** (95,400)	Frequency† (%)	Infants rehosp.††	Cost/ infant††† ($)	Total cost ($)
≤1500	16.2	25,650	38.2	9,798	3,920	38,408,160
1501-2500	12.5	69,750	19.0	13,252	1,560	20,673,120
					TOTAL:	$59,081,280

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* Average length of stay. McCormick, et al. at 993, Table 1.

** *See* note *, at 112-13 and accompanying text.

† This column represents the frequency with which infants in the various low birthweight categories require rehospitalization. Korenbrot II at Appendix B.

†† Frequency percentage multiplied by the number of infants.

††† Korenbrot II at Appendix B. It is important to note that these cost estimates refer to federal dollars only. The total Medi-Cal expenses (state and federal) would be double the figures in the text.

Taken together, the current costs of rehospitalization and neonatal intensive care for low birthweight infants is $638,364,300. This sum is compared to the initial savings to the federal government for providing such care with the reduction of low birthweight; that is, those low birthweight infants remaining even after comprehensive prenatal coverage. It is estimated that if comprehensive prenatal care is provided to the 396,000 Medicaid eligibles, 5.5% or 21,780 will deliver low birthweight infants. Of the 21,780, 7% or 1,524 will be very low birthweight; the remainder, 20,256 will be low birthweight.*

It is also estimated that if comprehensive prenatal care is provided to the 180,000 Medicaid ineligibles who are covered by Medicaid once they give birth, 7% or 12,600 will be low birthweight. Of the 12,600, 9% or 1,134 will be very low birthweight; the remainder, 11,466 will be low birthweight.**

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* The 5.5% figure was estimated from a review of the low birthweight rate of low-income women throughout the country who had had comprehensive prenatal care coverage. In Oakland, California, 3% (3:1-2). In Minnesota the rate was 5:5% (6:33). In rural Texas, 4.4.% (109:26). In the South Bronx, 6.3% (44.32). In California, 3.9% (91:52-59).

** The 7% figure was also estimated from the studies in note *, *supra*.

The expected cost to the government is thus computed as follows:

Table 5.

Expected Costs to the Federal Government
for Care of LBW Infants after Comprehensive Prenatal Care

NICU Costs

Birth-weight (gms)	Freq. (%)	No. of LBW infants (34,380)	Infants requiring NICU	Cost/ infant ($)	Total Cost ($)
1500	100	2,658	2,658	20,720	55,073,760
1501-2500	32.8	31,722	10,404	2,090	21,744,360
					$76,818,120

Rehospitalization Costs

Birth-weight (gms)	Freq. (%)	No. of LBW infants (34,380)	Infants/ rehosp.	Cost/ infant ($)	Total Cost ($)
1500	38.2	2,658	1,015	3,920	3,978,800
1501-2500	19	31,722	6,027	1,560	9,402,120
					$13,380,920
				TOTAL:	$90,199,040

In summary, the current cost of providing NICU and rehospitalization for low birthweight infants is $638,364,300, as compared to the expected cost of providing such care with the reduced incidence of low birthweight resulting from comprehensive prenatal care coverage, $90,199,040. This is obviously a tremendous savings, given the great disparity of costs, and results in an initial savings of $548,165,260, ($638,364,300 - $90,199,040). After subtracting the costs of providing comprehensive prenatal care, $187,084,040, the resultant real dollar savings to the federal government is $361,081,220.

The foregoing cost for providing comprehensive prenatal care can probably be decreased with the use of nurse-midwives instead of physicians in both prenatal care and delivery. On the other side of the equation, the current cost of providing NICU and rehospitalization is a very low figure considering the conservative estimates that 15% of the Medicaid eligibles and 20% of the Medicaid ineligibles will deliver low birthweight infants.

Further, the estimates for both NICU and rehospitalization include only Medicaid costs. Other federal programs which pay for both intensive care and rehospitalization include the Crippled Children's program and the MCH program. The MCH program alone provided a total of $7 million, or 11% of its total budget, for neonatal intensive care in 1978.* Finally, the federal dollar figure does not include the long-term costs such as treatment and institutionalization for physical and mental disabilities not requiring hospitalization that are more frequently associated with low birthweight.**

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* Better Management at Appendix I.

** For example, the lifetime costs of care for developmentally disabled individuals has been estimated to be between one-half and $6 million per individual, based on institutional costs of $20,000 a year with an average life of 40 years. 129 Cong. Rec. (Sen. Cranston) (daily ed. Jan. 26, 1983).

E. Other Long-Term Costs

The preceding section demonstrated the cost-effectiveness of providing preventive, prenatal care as compared to providing only two types of costly treatment for low birthweight infants. There exist, however, several other long-term costs to the infant, its family, and to society as a whole that are associated with low birthweight, which further strengthen the cost-effectiveness argument. Various studies have shown that while there has been an improvement in the prognosis for life and normal development for low birthweight infants since the 1960s, the incidence of both major and minor handicaps is still high.[1]

1. Developmental Delay/Congenital Anomalies

Low birthweight has been directly correlated with a high risk of severe impairment and severe developmental delay.* In a follow-up of the McCormick study,** data was collected to measure the incidence of delay/congenital anomalies among surviving infants at the end of the first year of life.[2] Results of the study showed that from a total of 4,377 infants, 14.3% of very low birthweight infants (less than 1500 gms) were severely impaired, compared to 1.6% of normal birthweight infants (more than 2500 gms).[1]

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* Shapiro, et al., Correlates of Death and Morbidity at One Year of Age, 136 Am. J. Obstet. gyn. 363 (1980). Severe impairment includes congenital anomalies such as mental retardation, Down's Syndrome, major cardiac malformations, congential cataracts, and cystic fibrosis. Moderate impairment includes cleft palate, clubfoot, and hypospadias (urethra open externally-down midline).

Severe developmental delay is based on an exam of gross and fine motor activities (scoring less than 70) and other developmental indices. An example is cerebral palsy.

** See 94:991

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[1] 38:85
[2] 124:363

Depending on the severity of impairment, both federal and state governments incur major expenses caring for the medical and nonmedical needs of the developmentally disabled, such as expenses of institutionalization, generic services, and special education, of the developmentally disabled. For institutionalized care alone, it has been estimated that approximately $315,250 will be incurred per case (1982 dollars).*

All levels of developmental disability (severe, moderate, or mild) can be influenced by prenatal care and birthweight.[2] The many and varied costs of treating and caring for developmentally disabled persons can thus be avoided by preventing the incidence of low birthweight through comprehensive prenatal care.

2. Physical Handicaps

Among the most common types of physical handicaps suffered by low birthweight infants are blindness, deafness, and major and minor birth defects.[1] Recently, incidences of moderate to severe deafness of 1-1.8% have been reported in very low birthweight infants.[2] Blindness seems to be the most predominant of physical handicaps.* In one study, the author estimated that in 1979, 546 infants were blinded from retinopathy of prematurity (retrolental fibroplasia) in the U.S.[3] Blindness results from oxygen being applied to resuscitate and maintain premature infants of low birthweight during the neonatal period.** The blood vessels in the retina constrict in response to a certain dose of oxygen and bleeding and tissue injury result in scarring (cicatricial disease) which may progress to cause blindness.***

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* Korenbrot II at Appendix B. This estimate is based on the present value of 20 years of institutionalized care for 95% of the severely delayed and generic services for the other 5% not institutionalized. Costs of care in the future were discounted at the State Treasurer's Portfolio rate of interest of 10% per year. Id.

It should be noted that "severely developmentally delayed" as defined in Korenbrot II differs from the definition used in Shapiro, et al. In Shapiro, severe impairment included congenital anomalies other than mental retardation which may not warrant institutionalization, whereas Korenbrot focuses solely on developmental disabilities requiring institutionalization, which accounts for the 95% rate of institutionalization. Korenbrot II at 5.

[1] 124
[2] 94

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* Of 7% of low birthweight infants who had insoluble physical problems, 6% had blindness. Koops at 349.

** Id. Apart from retrolental fibroplasia, there are several other potential long-term hazards of certain intervention techniques used in neonatal intensive care, adding to the costs associated with low birthweight. Infants undergoing phototherapy have been found to suffer from lactose intolerance, diarrhea, skin rashes, and dehydration. Deepening Crisis in Health Care at 144. Environmental hazards with the intensive care nursery such as emission of vinyl chloride gas, exposure to microcurrents and radiation from portable x-ray units are dangerous to infants. Id. Other hazards include radiant heaters, alkali therapy, high noise level of incubators, and arterial catheterization. Id. See also Stavis, R., Kraus A., Neonatal Intensive Care, Clinics in Perinatalogy (Mar. 1980).

*** Phelps at 925. This occurs primarily to very low birthweight infants (less than 1500 grams). According to Phelps, there is insufficient information about the amount of oxygen which will cause blindness, and very often these infants often stop breathing or require respirators neonatally, necesitating use of substantial amounts of oxygen.

[1] 80:87
[2] 38:87
[3] 111

The cost of treating and caring for the blind, the deaf, and those with birth defects that affect their productivity is difficult to calculate, but is certainly one of the costs associated with low birthweight. Of importance is the fact that Phelps, author of the aforementioned study, emphasizes that the number of cases of blindness in these infants will continue to rise until prematurity and low birthweight can be prevented. since this disorder is caused first by prematurity and only secondarily by oxygen.[1]

3. Learning Disabilities

Infants with low birthweight tend to have difficulty in school.[2] School failures have been noted in 30% of ten year old children of normal intelligence with a birthweight of less than 1500 grams.[3] The consensus of opinion from the older surveys leaves no doubt that the low birthweight child and particularly the very low birthweight child was at considerable disadvantage in the school classroom, even when no clinically detected handicap was present.[4]

A delay in speech development in low birthweight infants has also been documented.[5] In testing 96 infants at five years of age, researchers found that 33% of the boys and 26% of the girls had delayed onset of speech. At school age 31% of the boys and 18% of the girls had severe speech defects which included both receptive and expressive parameters of language. The normal

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1. 111
2. 22
3. 22
4. 38:88
5 80:346

school population had a 1.5% incidence of speech defects. School performance of 50% of the boys and 36% of the girls was not satisfactory.[1]

The costs of providing special education, testing, and medical treatment to improve or overcome learning disabilities are thus another long-term cost associated with low birthweight.

4. Intangibles

Low birthweight also produces several other adverse outcomes which result in less tangible costs, but which must nonetheless be included in the aggregate costs to the infant, its parents, and society in general.* For example, studies have revealed that low birthweight infants who require neonatal intensive care have the lowest interaction with mothers with weak social support systems.** These mothers visited least, touched least, and were least concerned about the development of their offspring.[2] This creates the potential for serious long-term relationship problems between mother and child. Similarly, because low birthweight infants are twice as likely to be rehospitalized than normal birthweight infants,*** they must be separated from their parents for extended periods. This physical separation prevents the normal parent-infant interaction in the earliest days of life which has been found not only to shape behavioral patterns, but the electrochemical circuits of the thinking process as well.[1]

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* The following is an illustrative list of problems reportedly associated with low birthweight. It is not intended to be an exhaustive list of long-term problems since they are not fully known.

** High-Risk Follow Up at 3. This included families where the fathers were abusive, had abandoned the family, or the couple were in the process of separation.

*** _See_ discussion at 117-119, _supra_.

1. 80
2. 22:4

A few studies report the correlation of low birthweight to child abuse. One study showed that low birthweight babies comprise 23.5% of reported child abuse of children who are less than one year of age. Among the factors precipitating such abuse were biologically impaired infants, limited parent-infant contact during the nursery period, and stress resulting from limited resources to care for the infant.[2] Another study found that of 255 infants discharged from a regional newborn intensive care unit to their parents, ten (or 3.9%) were subsequently reported as victims of maltreatment during the first year of life. Some of the family psychosocial characteristics significantly associated with the maltreatment included social isolation, family history of child abuse and neglect, inadequate child care arrangements, and serious marital problems. Maltreated infants were less mature at birth and had more congenital defects than their nursery mates. Finally, there was less family-infant contact during the prolonged nursery hospitalization in families in which maltreatment eventually occurred.[3]

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1. 22:4, 39:109
2. 22:4, 74:15
3. 69:629

Other emotional problems include the stress and strain of caring continuously for the infant; the shock of having to cope with an abnormal birth; prolonged parenting demands with little responsiveness from the infant; and atypical sleep-wake cycles.[1] How does one measure the "cost" of being normal or the diminished quality of parenting experience? Further, how does one measure the "cost" of trauma suffered by a family that must witness a neonatal intensive care episode? Thus, an incalculable cost is the tremendous human suffering that occurs from care and treatment of a low birthweight infant.

In the end, the financial costs are ultimately borne by society. Even mild impairment resulting from low birthweight may affect the lifetime productivity of a person, necessitating dependency on unemployment or welfare stipends. Also, many families burdened with large hospital bills may themselves be forced to enroll for welfare. These costs are wasteful and unnecessary, especially when it is clear that they can be substantially reduced through prenatal care.

F. Efforts to Reduce the Incidence of Low Birthweight Have Been Stymied by Federal Program Cutbacks in the Reagan Administration.

Many federal programs and services aid in reducing the incidence of low birthweight, and, in turn, reducing the federal costs of caring for low birthweight-associated illnesses and long-term problems. Yet despite their proven success rate and cost-effectiveness, the Reagan administration is determined to reduce federal spending or eliminate altogether these programs. The administration's policy is not simply foolish; it is disastrous. Any savings to be gained by cutting these programs will soon be consumed by the tremendous costs relating to low birthweight that the government will ultimately pay.

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[1] 22:3-5

The most disastrous cutbacks and regressive changes in federal programs include the following:

- not allowing federal AFDC assistance to mothers pregnant for the first time until their sixth month of pregnancy. Previously, states could claim federal reimbursement for AFDC for these mothers from the time the pregnancy was medically confirmed. Half the states did so. In addition, in many states federal assistance is no longer provided for medical benefits for the unborn child. Therefore, women pregnant for the first time have not only lost AFDC benefits, but also essential medical care.*

- for hundreds of thousands of pregnant women the Medicaid program pays for prenatal care and delivery services. Although the Reagan Administration proposed cutting a total of $11.7 billion out of Medicaid over four years, Congress passed $3.1 billion in Medicaid cuts in FYs 1982, 1983, and 1984 under the Omnibus Reconciliation Act of 1981. For FYs 1984, 1985, and

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* Children's Defense Budget at 82. A large proportion of first-time pregnancies are due to teenagers and unmarried women. In 1977, when 7.1% of the babies weighed 2500 grams or less at birth, 11% of the babies born to adolescents under 18 years were low birthweight babies. Better Health at 8. In 1975, the proportion of low birthweight infants among babies born to unmarried women was about twice as high as the proportion among babies born to married women (12.9% v. 6.5%). Id. at 17. There is some overlap, in that half of all births to unmarried women are to teenagers, id., but the incidence of low birthweight infants among these two groups is still above the national average. Denying benefits to first-time pregnant women will therefore result in an increased incidence of low birthweight infants who, as discussed earlier, will require greater costs in long-term care.

1986, the Administration has proposed cutting an additional $1.9 billion.*

- despite several Administration proposals to terminate WIC as a separate program and merge it into the Maternal and Child Health Block Grant, WIC is one of the few programs that has managed to escape budget cuts to date. However, WIC is still not free from further attacks. The Administration's FY 1984 budget proposes to hold the WIC program at the same funding level as in FY 1983 without any provision for inflation or rising costs to the program and despite the hundreds of thousands of women, infants, and children on waiting lists for this program.**

- in FY 1982 and FY 1983, the Administration proposed abolishing the Community and Migrant Health Centers and Family Planning Programs and replacing them with block grants at decreased funding levels. Presently, both programs are operating at FY 1982 funding levels. For FY 1984 the Administration has proposed freezing funding for the programs and again trying to include them in a block grant.***

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* Children's Defense Budget at 68, 78. In the decade before Medicaid, infant mortality rates changed very little. Following enactment of Medicaid, infant mortality rates fell sharply: from 25 deaths per 1,000 live births in 1965 to 13 deaths per 1,000 live births in 1979. Maternal mortality rates have also dropped significantly. Id. at 67. While many factors may have contributed to the decline in rates, it is certain that Medicaid played a large role by making coverage of prenatal care and delivery accessible to the poor.

** Children's Defense Budget at 130. WIC is one of the most successful of all federal programs. A study conducted at the Harvard School of Public Health found that WIC caused a marked reduction in the incidence of low birthweight infants. It also found that, because of the reduced incidence of low birthweight infants needing extended hospital care after birth, each $1 spent in the prenatal component of WIC actually averted $3 in hospital costs. Id.

*** Children's Defense Budget at 70. In 1981, 827 community health centers provided comprehensive care in the most medically underserved urban and rural areas of the nation. In addition, some 128 migrant health centers reached families in the migrant stream--a population in which almost 20% of women, four times the national average, receive little or no prenatal care, and in which nearly half of all women have experienced at least one out-of-hospital birth. Studies have shown that community and migrant health centers deliver care that is high quality and cost-effective, and can reduce hospitalization rates between 25% and 44%. Id. (footnote continued on next page)

- devastating cuts in AFDC took effect in FY 1982 and FY 1983. The Omnibus Budget Reconciliation Act of 1981 slashed the federal AFDC program by slightly over $1 billion for FY 1981. Combined with a resulting loss in state matching funds, this constitutes a total AFDC cut of almost $2 billion. Then the Tax Equity and Fiscal Responsibility act of 1982 cut federal expenditures for AFDC by an additional $85 million for FY 1983.*

- the Maternal and Child Health Block Grant** was created and funded in FY 1982 at $373 million, an 18% cut from 1981 appropriation levels. The MCH Block Grant's FY 1983 funding is frozen at the FY 1982 level and the Administration intends to maintain this level for FY 1984.***

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(footnote cont'd.)
During 1981 over 4.5 million young women and mothers received family planning and health education services at about 5,000 family planning sites nationwide. In addition to delivering important health services, the programs yield a documented savings of $1.80 for every $1.00 invested. Id.

* Children's Defense Budget at 81. Welfare administrators report that 10 to 25 percent of the families that lost AFDC due to FY 1982 cuts subsequently had to return to AFDC support. Many of these families previously had received only partial AFDC grants due to earned income, and returned to the rolls when they lost jobs. Id. at 85.

** This block grant, which has been implemented by all 50 states, combined the previous Title V program, see note 106, infra, with six other specialized programs---Sudden Infant Death Syndrome, Lead Paint Poisoning Prevention, Genetic Screening, Hemophilia Treatment, Adolescent Pregnancy Services, and Supplemental Security Income Rehabilitation Services for Disabled Children. Id. at 69.

*** Children's Defense Budget at 69. In 1980 the Title V Maternal and Child Health and Crippled Children's Program reached nearly 12 million children and mothers with services ranging from basic prenatal care, checkups, and immunizations to the most sophisticated types of medical care for high-risk newborns and children suffering from handicapping conditions.

The two most common justifications for these cutbacks and changes are (1) to save the government money and (2) the states will provide a "safety net" to fill in the gaps left by billions of federal social program cutbacks. The foregoing discussion on the comparative costs of prenatal care and low birthweight-related expenses clearly shows that even if the government saves some money by cutting back on these programs, in the long run the government will spend much more to treat the conditions it has created.

The second justification is a myth. In fact, most states are neither willing nor able to replace the services and programs provided by the federal government. Many of the states' anticipated year-end balances for FY 1983 show either substantial deficits or no balances at all.[1] Every state has reduced its Medicaid program for mothers and children by cutting back on services or making eligibility more difficult to obtain or both.[2] Forty-seven states reported cutbacks in the Title V Maternal and Child Health Block Grant program through restrictions in eligibility and/or services.[3] In 1982 human services officials from 55 cities nationwide ranked health care programs as the most common area affected by federal budget cuts.[4] With fewer federal and state dollars to administer these programs,

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1. 29:34
2. 29:74
3. 29:75
4. 29:68

it takes no stretch of the imagination to realize that state and local governments will shift program support from preventive care to crisis acute care, since preventive care is elective, acute care necessary.* The Reagan Administration is therefore engaging in wishful thinking to suppose that the states will fill in the gaps left by federal cuts.

In summary, it is ironic that the Reagan Administration perseveres in its efforts to reduce federal spending in programs and services that have proven to be successful and cost-effective. These reductions leave many women and children without access to care and at increased risk of illness, disability, and death, the cost of which will ultimately be borne by the federal government.

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* Korenbrot II at 1.

VII. REJECTING THE SURGEON GENERAL'S, THE COMPTROLLER GENERAL'S AND THE SELECT COMMITTEE'S 1980 CONCLUSIONS ON MATERNAL AND CHILD HEALTH, THE CURRENT ADMINISTRATION SETS POLICIES DESTINED TO INCREASE INFANT MORTALITY AMONG THE POOR, AMONG MINORITIES.

The federal government was thrice told in 1980 by such authorities as the Comptroller General, the Surgeon General, and Congress' Select Panel for the Promotion of Child Health that the nation's capacity to reduce the infant mortality rate and the racial infant death gap was easily in grasp. The current administration, coming in on the heels of these findings and blinded by its unique philosophical predilictions, nonetheless discarded these conclusions and, in the process, discarded the lives of hundreds of babies, mostly poor and mostly Black.

In January 1980, the Comptroller General reported to Congress on: Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome. Shortly thereafter, in the Fall of 1980, the Surgeon General issued Promoting Health/Preventing Disease which established health goals for 1990 with very specific objectives for pregnancy and infant health. The Reagan Administration has formally embraced these objectives, including the goal of reducing infant mortality to 9/1000 by 1990.[1] Finally, in December 1980, the Select Panel for the Promotion of Child Health issued three volumes entitled: Better Health for Our Children: A National Strategy.

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[1] 11

Each report focuses on the United States' relatively high overall infant mortality rate, on the racial death gap, and on low birth weight as the primary target if the prospects for infant survival, especially for minority infants, are to be improved. Each sets forth the same solutions and the same priority: access to comprehensive prenatal care for all poor, pregnant women.

Specifically, after surveying many experts and state authorities, the Comptroller General reported its findings:

> "Women who receive inadequate prenatal care are most likely to have underweight babies (a characteristic associated with nearly two-thirds of infant deaths), although other facts (such as mother's age, education, socioeconomic level, etc.) also influence pregnancy outcome. Although it is not always known which factor has the greatest influence, authorities continually stress the critical nature of prenatal care. State MCH directors responding to our questionnaire indicated that expanding or improving prenatal care services was their highest priority for improving pregnancy outcome. Also, according to BCHS [Bureau of Community Health Services],
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> > 'Few health activities have as much potential for promoting health at crucial points in the life cycle. While project may find the delivery of these services expensive, their effective provision can ultimately reduce some health care costs and can greatly improve the quality of life for many patients. [Emphasis supplied.] [1]

The Comptroller General then proceeds to describe the specific changes and improvements necessary if federal programs are to insure adequate prenatal care for all poor, pregnant women. The list is not new; quite the contrary, it reads like a well-worn litany whose words have been repeated so often they are, apparently, no longer heard. While "preventive care" may lack the catchy ring of "new federalism" or "right to life," preventive care is *the* known solution to the primary condition associated with infant mortality: low birthweight. Solicitous sentiments are no substitute for real solutions.

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[1] 142:83

Similarly, the Surgeon General described the same problem and prescribed the same solution, *i.e.*, prenatal care:

> "Assuring all infants a healthy start in life and enhancing the health of their mothers are among the highest priorities in preventing disease and promoting health. The principal threats to infant health are problems associated with low birth weight and birth defects which can lead to lifelong handicapping conditions. Of particular concern are the disparities in the health of mothers and infants that exist between different population groups in this country. These differences are associated with a variety of factors, including those related to the health of the mother before and during pregnancy as well as parental socioeconomic status and lifestyle characteristics. Although the precise relationship between specific health services and the health status of pregnant women and their infants is not certain, *the provision of high quality prenatal*, obstetrical, and neonatal care, and *preventive services during* the first year of life, *can reduce a newborn's risk of illness and death*. Of particular concern are adolescents, whose infants experience a high degree of low birth weight and whose health problems should be addressed in broad context taking into consideration social and psychological implications."[1] [Emphasis supplied.]

The Surgeon General then set health goals for 1990. They include reducing infant mortality to 9/1000 for the entire population and for the minority population to 12/1000. The latter, if achieved, would reduce the current rate for minioritieѕ by 50% and, in many localities, by 100% or more. While the Reagan Administration has formally adopted these goals, it has repudiated the only recognized means of reaching these same objectives. Specifically, the Surgeon General recommended as a "strong priority":

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[1] 139:15

> "-- early and continuing prenatal care, particularly for those at greatest risk--poor, poorly educated women, those near the beginning or the end of their reproductive age, those with previous pregnancy loss and those with recent pregnancy;
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> * * *
>
> -- systems of care that reach everyone with basic services, emphasizing advantageous personal health, behavior and including outreach, education, and easy access to community-based services without social, economic, ethnic or time or distance barriers."[1]

Yet, the current administration has dismantled or destroyed the very federal health programs which could have fulfilled these objectives. (See discussion supra, pp. 128 - 133) In their place, the Reagan Administration offers the "volunteerism" of 50 organizations who have launched a "Healthy Mothers/ Healthy Babies" campaign, albeit well intended:

> "-- To supply information that encourages healthy habits for pregnant women and women planning pregnancy.
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> -- To motivate pregnant women to protect their health through regular prenatal care and good nutrition."[2]

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[1] 139:15
[2] 88:2

Encouraging women to seek prenatal care when none is available is a futile exercise which, given the devastating consequences of little or no prenatal care, borders on the sadistic. Yet, this "private-public initiative"[1] constitutes the entire Reagan effort to reduce infant mortality and to achieve the Surgeon General's 1990 goal.

Finally, in late 1980, the Select Panel for the Promotion of Child Health delivered its three volume report to Congress and DHS. The panel's mandate was to examine the state of "children's and expectant mothers" health, and to recommend legislative and administrative action where necessary to improve the national health profile. In its first chapter identifying "major concerns," the panel stated the case for widespread access to comprehensive prenatal care:

> "The potential benefits of preventive care and health promotion are especially great for mothers and young children... The main problem, therefore, is not that we lack effective preventive care techniques to assist infants, young children, and pregnant women, but that techniques of known effectiveness still have not been applied widely enough... Prenatal care is clearly related to positive pregnancy outcome. Many of the risks associated with low birth weight can be identified in a first prenatal visit, and steps can be taken to prevent or correct them. Conversely, late care or no care is associated with low birth weight, increased prematurity rates, increased stillbirths, and increased newborn mortality. A pregnant woman who receives no prenatal care is three times as likely as others to have a low birth weight baby (one weighing less than 2,500 grams, or about 5.5 pounds). In 1977, neonatal, post-neonatal, and infant death rates were four times higher

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[1] 9:503

> for babies born to women who received no prenatal care than for those receiving at least some care. [footnote deleted.]
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> Despite the effectiveness of timely prenatal care, almost 10% of all pregnant women receive none at all or only belated (third trimester) care. These percentages are significantly higher among poor, black, adolescent, and unmarried women, those in rural areas, and those over 35--the very groups most likely to be at high risk from other causes."[1] [Emphasis supplied.]

The remedies petitioners seek are, in great part, an updated version of the Select Panel's recommendations. Petitioners' proposals are, if anything, more modest insofar as petitioners emphasize administrative decisions tailored to the current structure and funding of federal health programs, rather than seeking legislative changes.

The goals, then, of the Select Committee, the Surgeon General, and the Comptroller General are identical: a reduction of the high rates of infant mortality among the poor through insured access to comprehensive prenatal care.

This administration contends that its poor standing in the Black community stems from misinformation and bad press. For the thousands of Black parents who needlessly lost their babies in the past several years, no amount of improved public relations can fill the emptiness they feel. Action--a solid program of preventive care available to all pregnant, poor women --will speak louder than words.

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1. 138:23-24

VIII. REMEDIES

A. Introduction

Petitioners seek a host of administrative remedies which, taken together, could better insure that all poor, pregnant women have access to comprehensive prenatal care. Some of the proposed measures merely seek clarification and elaboration of options currently available to the states which, despite their obvious cost-effectiveness, have not been implemented. Through aggressive leadership and careful coordination, the federal government could encourage the states to implement changes which would maximize the use of both federal and state dollars for maternal and child health. Other proposed measures would mandate standards for comprehensive prenatal care and insure, wherever possible within the limits of federal authority, their implementation.

Initially, petitioners set forth a proposal for extensive coordination among current programs through the appointment of a Select Coordinator. The petition's remedies are then discussed programatically under Title V, Medicaid, EPSDT, and nurse-midwives. Finally, petitioners propose a national education campaign.

B. Coordination

Despite continuing, resounding exhortations from all corners of the health delivery system and from oversight agencies for improved federal coordination of health programs serving low income pregnant mothers and infants, the need remains unfulfilled. Yet, such coordination would be cost effective by eliminating duplication and ensuring that assistance would be targeted to the low income, high-risk pregnant women and infants who need it most.

Accordingly, petitioners request the institution of the following measures which HHS is empowered to implement through its rulemaking authority:

a. Designation by the Secretary of Health and Human Services of a Select Coordinator for Improving Pregnancy Outcome. The Select Coordinator, formally designated as Deputy Assistant Secretary for Maternal and Child Health, would have jurisdiction over the Health Care Financing Association (Medicaid), the Bureau of Health Care Delivery and Assistance (Title V, MCH, and Title X, Family Planning) the Office of Human Developmental Services (Title XX, Social Services Block Grants), the Office of Family Assistance (Social Security), and community and migrant health centers (Public Health Service). The Select Coordinator, appointed with the participation of petitioners and other interested persons who represent the high-risk population in question, would have ample influence and authority to coordinate all programs and funding sources serving low income mothers and infants and would provide leadership in the following areas:

(i) help develop the national education campaign (described infra, pp. 153 - 155) to promote the use of health care services essential to improving pregnancy outcome;

(ii) develop specific annual national goals and timetables to reduce low birth weight, particularly among low-income and minority mothers, and requiring state plans, whether Medicaid or Maternal and Child Health Block Grant, to describe how they intend to meet such goals and timetables;

(iii) develop a clearinghouse and provide technical assistance to assist states in replicating programs which have been effective in reducing infant mortality and low birth weight.

b. In addition, the Select Coordinator, working with individual HHS agencies, should oversee the development and promulgation of the following rules to ensure coordination of programs:

(i) the establishment of a uniform definition of comprehensive prenatal care, to govern the delivery and financing of maternity services under all programs administered by HHS including but not limited to the Maternal and Child Health Block Grant, Medicaid, Medicare, EPSDT, Title V, Title X, the Adolescent Family Life Program and Community and Migrant Health Centers;

(ii) as a condition of federal financial participation, require the State Medicaid and Title V agencies to adhere to the uniform Comprehensive Prenatal Care definition (*infra*., p. 146) in providing or financing prenatal care services under these programs;

(iii) require assurances from states in their state plans that services provided under Medicaid and the Maternal and Child Health Block Grant are coordinated so that:

(a) related services will be housed together whenever feasible in easily accessible locations with hours convenient for most patients;

(b) pursuant to 42 U.S.C. § 1396a(a)(11), State Medicaid agencies shall grant qualified provider status to all Title V providers meeting otherwise applicable provider qualification standards; and pursuant to 42 U.S.C. § 705, shall require that all qualified Title V clinical providers shall participate in the Medicaid Program;

(c) Title V providers will be required pursuant to 42 U.S.C. § 705, when the services they offer are less than those offered by Medicaid providers covered under HHS's

Comprehensive Prenatal Service definition, to refer:

(1) Medicaid eligibles to other Medicaid providers for such comprehensive services; and

(2) for non-Medicaid eligible patients to refer such patients to providers, including providers of in-patient services, who will furnish care at little or no cost;

(d) Medicaid reimbursement will constitute "first dollar" coverage for all Comprehensive Prenatal Care services furnished by publicly funded providers including Title V funded providers, community health centers, migrant health centers and providers funded under Title X of the Public Health Service Act.

C. Title V

Since the passage of OBRA (Omnibus Budget Reconciliation Act) of 1981 and TEFRA (Tax Equity and Fiscal Responsibility Act) of 1982, the federal government has frequently approved state plans which are merely carbon copies of the statute and provide no real assurances of meeting the objectives of Title V. To ensure meaningful compliance, pursuant to §42 U.S.C. §705(1), the Secretary should promulgate rules implementing the Title V statute which, at a minimum, would require that a State Plan:

(1) is based on a needs assessment that identifies the geographical location of those in greatest need, what those unmet needs are, what providers already exist, where they are located, what services they provide and their capacity, what other health-related programs exist, and an assessment of the transportation available to reach providers;

(2) in assessing which communities are in need, utilizes a standard of "high-risk" which is defined by the Secretary in federal rules in accordance with commonly recognized medical standards;

(3) allocates funds to service sites in a manner that maximizes convenience, defined by the Secretary to take into account location, hours, and transportation services available;

(4) includes a coordination plan for services which maximizes resources, accommodates scheduling and transportation problems, and ensures that patients transferred between programs are not lost;

(5) requires that clinical providers satisfy the Comprehensive Prenatal Care definition for adequate staffing ratios to insure sufficient provision of services;

(6) provides for the training and use of community outreach workers;

(7) complies with criteria promulgated by the Secretary for assessing whether or not a state's expenditure of Title V funds on prenatal services is reasonably sufficient for the state to meet its annual goal of reducing the incidence of low birth weight and infant mortality [B(1)(a)(ii), supra];

(8) assures that there will be no discrimination in hiring, in providing services, and in closure or relocation of services;

(9) provides that data is collected to identify unmet needs;

(10) complies with rules which the Secretary will promulgate implementing the "free care" and "sliding scale fee" requirements of the statute.

D. Definition of Comprehensive Prenatal Care

Provision of comprehensive prenatal care should be part of each state plan. Every state should provide adequate assurances that it will deliver, at a minimum, the following services:

- physical examinations once every 4 weeks for the first 28 weeks of pregnancy, every two weeks until the 36th week and weekly thereafter;
- routine laboratory tests including blood and urine analyses;

- screening and counseling regarding nutrition, substance abuse, genetic abnormalities, and family planning;
- education on topics, including but not limited to training in labor and delivery, breastfeeding, use of medication, infant care and parenting;
- a psycho-social assessment;
- labor/delivery services available in a hospital or clinic;
- a follow-up exam for the mother, which includes family planning education and services;
- a well-baby exam;
- sufficient ratios of qualified staff-to-patients are maintained to provide the above described services.

E. Medicaid

Medicaid funds most maternal and child health care needs for poor women in this country. Repeatedly, Medicaid has been shown to increase dramatically minority and low-income women's access to health care which, in turn, has significantly improved their health status and that of their infants.[1] Severe budget cuts have reduced the numbers of mothers and children served just when the feminization of poverty has produced a greatly expanded need for health care coverage.

The declining percentage of poor pregnant women and infants covered by Medicaid[2] stems not only from budget cuts but from the federal government's failure to encourage state extension of coverage despite the genuine cost-effectiveness of doing so. Many options currently available to states would enable much greater numbers of low income women and children to be served, but the federal government's failure to clarify coverage possibilities has impeded the expansion of coverage.

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[1] 150:68
[2] 8:27

Petitioners request that HHS formally issue an eligibility rule for pregnant women which would encourage expansion of coverage for pregnant women and infants by clearly delineating the following options:

1. Coverage for Financially Needy Pregnant Women.

42 U.S.C. §1396d(a)(viii) and 42 U.S.C. 1396a(a)(10)(A)(iii) enable states to extend coverage to all pregnant women who do not satisfy the AFDC categorical test but whose income and resources are at or below state AFDC levels. This option would cover both single and married pregnant women, thus halting the misguided federal policy of requiring coverage only for single-parent families, a policy which has forced many husbands to abandon their wives so that their children are not denied health care. It would also cover first-time pregnancies, another category which has been inappropriately limited.

2. Coverage of Medically Needy Pregnant Women and Children.

The 1981 Medicaid amendments provide that states can institute a medically needy program limited to maternity care for pregnant women and ambulatory services for children

(42 U.S.C. §1396a(a)(10)), without assuming responsibility for the entire medically needy population. As such, the cost of instituting a medically needy program for pregnant women and children would require minimal additional expenditures. Any state which chose to implement options one and two would then have a Medicaid program covering all poor, pregnant women. If, despite the known cost-effectiveness of such a poicy, a state declined to establish eligibility for all poor, pregnant women, the federal government should clarify the following, less comprehensive options:

3. Coverage for First-Time Pregnancies.

While a woman pregnant for the first time often cannot obtain AFDC at all or only obtains it during her last trimester, Medicaid benefits can nevertheless be provided from the time pregnancy is determined, 42 U.S.C. §1396a(a)(10)(C)(ii)(II). This group constitutes a subset of all financially needy pregnant women. A state that declines to expand coverage to all financially needy pregnant women still might choose to cover this category, which frequently would include first pregnancies of adolescents. Teenage pregnancy is inherently high risk; babies born to those under 15 are almost twice as likely to die in infancy and to be of low birth weight than babies of mothers in their twenties. Comprehensive prenatal care has consistently reduced these risks.

4. Coverage for Financially Needy Children and Pregnant Women

42 U.S.C. §1397a(a)(10)(A)(ii) and 42 U.S.C. §1396d(a)(1) provides that states may cover "financially needy" children as optional categorically needy beneficiaries. These children are defined by law as children who meet their state's AFDC financial eligibility criteria, but who are not "dependent" as defined by Title IV-A of the Social Security Act. States can cover all of these children and pregnant women or reasonable categories of such women and children. Extending coverage to financially needy children would mean access to much needed prenatal and baby care. Specifically under this option, states could cover pregnant, married women and pregnant adolescents from two-parent families.

5. A Medicaid Standard for Comprehensive Prenatal Care.

The Select Coordinator should insure that women receiving their prenatal care either through Title V or Medicaid are provided comprehensive prenatal care. The mechanism for insuring this through Title V was previously discussed, i.e., making comprehensive prenatal care a component of each state plan (see supra, pp. 144 to 146). An identical standard of comprehensive prenatal care can be established through Medicaid and EPSDT by amending current regulation 42 CFR 440.230(b) which requires that all Medicaid programs provide services sufficient in "amount, scope, and duration" to achieve their purposes, to include the definition of comprehensive prenatal care, supra, p. 146.

F. EPSDT (Early and Periodic Screening, Diagnosis and Treatment)

EPSDT provides for regular health assessments for all persons under the age of 21 and is mandatorily available to all categorically needy Medicaid eligibles. These health assessments include screening, laboratory work, and appropriate treatment. To insure that these preventive measures are fully accessible, EPSDT requires specific outreach efforts and assistance with transportation and scheduling.

Through clarification of options and establishment of standards, EPSDT could be used to insure prenatal care and well-baby care for a number of women and infants who might otherwise not be covered. Petitioners specifically propose the following:

1. Service Options Under EPSDT

HHS should clarify through regulations that those teenagers normally eligible for EPSDT screening and treatment should receive appropriate OB-GYN services through the program, including family planning services and, if pregnant, prenatal care.

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2. Mandatory Comprehensive Prenatal Care

Currently, HHS requires that, at a minimum, treatment provided through EPSDT include vision, dental, and hearing services, 42 CFR 440.230. HHS should expand the mandatory treatment categories to include comprehensive prenatal care provided for all EPSDT eligibility categories. Additionally, comprehensive prenatal care should include all of the components set forth above for Medicaid and Title V, supra, pp. 146 to 147.

3. Well-Baby Care and Infant Hospitalization

EPSDT already requires that each eligible baby receive a neonatal examination, i.e., an exam within the first 28 days. Through regulation, HHS should expand this requirement to include in addition to the neonatal exam the accepted schedule for the entire first year of well-baby care promulgated by the American Academy of Pediatrics.

Additionally, HHS should clarify that the neonatal examination provided for newborns under EPSDT constitutes an EPSDT "screen" which would then permit states to provide those infants with unlimited diagnosis and treatment including hospitalization, if necessary.

G. Nurse-Midwives

In order to maximize the use of nurse-midwives in providing prenatal care and obstetrical services to eligible

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women, HHS should issue the following rules:

1. as a condition of participating in the Medicare Program, states where nurse-midwives are legally authorized to practice to deliver babies should require all hospitals which receive Medicare reimbursement to provide admitting privileges for nurse-midwives;
2. similarly, in those states where nurse-midwives are legally authorized to practice to deliver babies, all Hill Burton Hospitals should be required to provide admitting privileges under their community services requirement;
3. amend current 42 CFR 440.220 to require that prenatal care services provided by nurse-midwives shall be reimbursable not only for the categorically needy, as it presently reads, but also for the medically needy. This expansion would only apply in those states where nurse-midwives are legally authorized to practice to provide such prenatal services.

H. National Educational Campaign

The federal government has already demonstrated its capacity for successful campaigns which combine public information and persuasion. It is the rare American who does not know and comprehend Smokey the Bear's message: "Only you can prevent forest fires!"

Similarly, the Department of Health and Human Services' Office of Health Promotion, in conjunction with petitioners and the Administrative unit responsible for maternal and child health pursuant to 42 U.S.C. §708(a)(c), can play a critical role in developing an education campaign which will provide information to pregnant mothers and the public at large about, but not limited to, the following topics:

1. The importance of early and comprehensive prenatal and neonatal care;
2. Identification and description of the varying conditions which are responsible for high-risk pregnancies;
3. Where to go and whom to contact to become Medicaid eligible and/or obtain publicly funded services for pregnant women and newborns;
4. Nutritional requirements during pregnancy with dietary suggestions tailored to the varying populations at risk;
5. The availability of publicly funded food programs which can assist pregnant women in obtaining or maintaining adequate nutrition during pregnancy, including WIC and food stamps;
6. The potential risks during pregnancy of smoking, alcohol, and the use of drugs, whether by prescription, over-the-counter or bought on the street; and
7. The availability of specific programs serving pregnant teenagers.

The wording should be simple, appear in languages other than English, and include graphic illustration wherever possible. The use of radio, TV and billboards, in addition to traditional posters and printed brochures, is essential. In sum, development of a multi-media campaign, thoughtfully designed to reach the greatest numbers of those at highest risk for pregnancy outcome, should be initiated immediately. Such a campaign will allow people to make informed choices about their lives, and the lives of their children.

I. Additional Federal Dollars

The cost effectiveness of the WIC Program, of prenatal care provided through Title V and of nurse-midwifery training has been demonstrated in other portions of this petition. Each of these programs has suffered cut-backs and/or severe erosion through inflation. While this petition is directed to HHS' capacity to take administrative action, petitioners cannot present a complete picture of the remedies without emphasizing the need for renewed federal funding in these three areas.

J. Additional Federal Legislation

Petitioners emphasize that the proposed remedies set forth above do not include legislative approaches which could definitively enhance this country's capability of reducing low birth weight and infant mortality, especially among the low income, minority population. By focusing on administrative solutions, petitioners in no way suggest that legislative approaches are not also necessary and urgent. Petitioners address administrative remedies because of their immediate potential for implementation. Nonetheless, petitioners believe that the evidence they present constitutes a compelling case for Medicaid reforms for mothers and children, the funds for which have been included by Congress in the first budget resolution for fiscal year 1984.

Dated: June 29, 1983.

Respectfully submitted,

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By
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APPENDIX

The table below consists of representative data from the Public Advocates Survey. Included are total live births and deaths for Blacks and whites and infant mortality rates for the 45 cities surveyed for 1980. The entire data set includes 1978-1981. Additional data is still being collected and analyzed by Dr. Jeffrey Gould at the University of California School of Public Health. Inquiries regarding that data and publication thereof may be directed to him.

Infant Mortality Rates for 45 Cities Studied

	1980
1. New York*	
White total live births	53,446
White infant deaths	801
White IMR	15
Black total live births	43,466
Black infant deaths	791
Black IMR	18.2
2. Washington, DC *,**,***	
White total live births	1,373
White infant deaths	17
White IMR	13.1
Black total live births	7,884
Black infant deaths	209
Black IMR	26.6
3. Seattle, WA	
White total live births	4,447
White infant deaths	52
White IMR	11.9
Black total live births	963
Black infant deaths	16
Black IMR	16.8

	1980
4. St. Louis, MO*,**,***,****	
White total live births	3,380
White infant deaths	39
White IMR	11.8
Black total live births	4,832
Black infant deaths	108
Black IMR	22.5
5. Philadelphia, PA*,**,***	
White total live births	12,492
White infant deaths	168
White IMR	13.5
Black total live births	12,411
Black infant deaths	280
Black IMR	22.6
6. Newark, NJ	
White total live births	2,169
White infant deaths	26
White IMR	12.4
Black total live births	3,854
Black infant deaths	89
Black IMR	23.3
7. Jackson, MS*,***	
White total live births	1,895
White infant deaths	15
White IMR	8.4
Black total live births	3,001
Black infant deaths	68
Black IMR	22.7
8. New Orleans, LA***	
White total live births	2,873
White infant deaths	33
White IMR	11.8
Black total live births	7,478
Black infant deaths	174
Black IMR	23.4

	1980
9. Houston, TX*,**,***,****	
White total live births	15,289
White infant deaths	171
White IMR	11.2
Black total live births	10,161
Black infant deaths	170
Black IMR	16.8
10. Greensboro, NC*,	
White total live births	1,180
White infant deaths	10
White IMR	8.5
Black total live births	960
Black infant deaths	9
Black IMR	10.4
11. Detroit, MI	
White total live births	5,971
White infant deaths	66
White IMR	11.2
Black total live births	
Black infant deaths	
Black IMR	25.1
12. Dallas, TX*,**,***,****	
White total live births	7,228
White infant deaths	78
White IMR	10.9
Black total live births	6,421
Black infant deaths	118
Black IMR	18.4
13. Atlanta, GA*,***	
White total live births	2,570
White infant deaths	30
White IMR	11.7
Black total live births	6,758
Black infant deaths	135
Black IMR	20.1

	1980
14. Chicago, IL*,***,****	
White total live births	27,224
White infant deaths	402
White IMR	14.8
Black total live births	30,492
Black infant deaths	789
Black IMR	25.9
15. Baltimore, MD*,***,****	
White total live births	4,129
White infant deaths	52
White IMR	12.6
Black total live births	8,191
Black infant deaths	172
Black IMR	21.0
16. Miami, FL*,**,***	
White total live births	14,345
White infant deaths	147
White IMR	10.3
Black total live births	8,267
Black infant deaths	138
Black IMR	16.8
17. Las Vegas, NV*	
White total live births	6,391
White infant deaths	56
White IMR	8.9
Black total live births	1,139
Black infant deaths	25
Black IMR	22.8
18. Jacksonville, FL*,**,***	
White total live births	6,618
White infant deaths	66
White IMR	10.0
Black total live births	3,335
Black infant deaths	66
Black IMR	19.8

	1980
19. Norfolk, VA*	
White total live births	2,765
White infant deaths	43
White IMR	15.9
Black total live births	2,256
Black infant deaths	32
Black IMR	14.2
20. Cleveland, OH*	
White total live births	5,281
White infant deaths	86
White IMR	16.3
Black total live births	5,461
Black infant deaths	162
Black IMR	29.7
21. San Diego, CA*	
White total live births	17,791
White infant deaths	275
White IMR	15.5
Black total live births	2,660
Black infant deaths	56
Black IMR	21.4
22. Cincinnati, OH*	
White total live births	4,063
White infant deaths	49
White IMR	12.3
Black total live births	2,970
Black infant deaths	54
Black IMR	18.2
23. Toledo, OH*	
White total live births	4,515
White infant deaths	49
White IMR	10.9
Black total live births	1,654
Black infant deaths	36
Black IMR	21.8

		1980
24.	Columbus, OH*	
	White total live births	7,058
	White infant deaths	71
	White IMR	10.1
	Black total live births	3,007
	Black infant deaths	49
	Black IMR	16.6
25.	Oakland, CA*	
	White total live births	9,663
	White infant deaths	98
	White IMR	10.2
	Black total live births	4,036
	Black infant deaths	64
	Black IMR	15.9
26.	Phoenix, AZ*	
	White total live births	24,317
	White infant deaths	311
	White IMR	12.8
	Black total live births	1,372
	Black infant deaths	27
	Black IMR	20.4
27.	Tucson, AZ*	
	White total live births	7,925
	White infant deaths	57
	White IMR	7.2
	Black total live births	382
	Black infant deaths	6
	Black IMR	18.3
28.	Pittsburg, PA*	
	White total live births	3,250
	White infant deaths	35
	White IMR	10.8
	Black total live births	1,846
	Black infant deaths	54
	Black IMR	29.3
29.	Nashville, TN*	
	White total live births	5,134
	White infant deaths	53
	White IMR	10.5

Nashville, TN (Continued)	1980
Black total live births	2,205
Black infant deaths	37
Black IMR	17.2

30. Birmingham, AL*

White total live births	6,151
White infant deaths	68
White IMR	11.1
Black total live births	4,772
Black infant deaths	95
Black IMR	20.1

31. Milwaukee, WI*

White total live births	7,789
White infant deaths	90
White IMR	11.6
Black total live births	3,934
Black infant deaths	73
Black IMR	18.8

32. Louisville, KY*

White total live births	8,603
White infant deaths	88
White IMR	10.3
Black total live births	2,596
Black infant deaths	57
Black IMR	22.3

33. Kansas City, MO*

White total live births	4,734
White infant deaths	52
White IMR	11.0
Black total live births	2,703
Black infant deaths	42
Black IMR	15.9

34. Oklahoma, NE

White total live births	5,702
White infant deaths	86
White IMR	15.1
Black total live births	1,524
Black infant deaths	33
Black IMR	22.3

35. Minneapolis, MN	1980
White total live births	63,067
White infant deaths	611
White IMR	9.7
Black total live births	1,514
Black infant deaths	31
Black IMR	20.5
36. Forthworth, TX	
White total live births	5,921
White infant deaths	71
White IMR	12.0
Black total live births	2,025
Black infant deaths	42
Black IMR	21.2
37. Portland, OR	
White total live births	7,666
White infant deaths	102
White IMR	13.4
Black total live births	797
Black infant deaths	14
Black IMR	17.6
38. San Francisco, CA	
White total live births	3,290
White infant deaths	42
White IMR	12.8
Black total live births	1,610
Black infant deaths	28
Black IMR	17.4
39. San Jose, CA	
White total live births	11,555
White infant deaths	175
White IMR	15.2
Black total live births	1,230
Black infant deaths	14
Black IMR	11.4
40. Los Angeles, CA	
White total live births	42,303
White infant deaths	541
White IMR	12.8

Los Angeles, CA (Continued)	1980
Black total live births	18,613
Black infant deaths	390
Black IMR	21.0
41. Memphis, TN*	
White total live births	6,057
White infant deaths	69
White IMR	11.4
Black total live births	7,711
Black infant deaths	154
Black IMR	20.0
42. Atlantic City, NJ	
White total live births	212
White infant deaths	9
White IMR	42.5
Black total live births	384
Black infant deaths	11
Black IMR	31.1
43. Youngstown, OH*	
White total live births	976
White infant deaths	11
White IMR	11.3
Black total live births	893
Black infant deaths	25
Black IMR	29.1
44. San Antonio, TX*,****	
White total live births	4,812
White infant deaths	46
White IMR	9.6
Black total live births	1,169
Black infant deaths	30
Black IMR	26.5
45. Richmond, VA***	
White total live births	1,264
White infant deaths	16
White IMR	13.4
Black total live births	2,168
Black infant deaths	58
Black IMR	26.8

The asterisk indicate cities providing Survey data for the following categories:

*City providing low birth weight (LBW) date by race.

**City providing very low birth weight (VLBW) data by race.

***City providing teenage pregnancy data by race.

****City providing prenatal care data by race.

(An Administrative Petition to the President for the United States, et al. Re: Immediate Executive Action to Alleviate the Nationwide Inner City Food Crisis)

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IN THE UNITED STATES OF AMERICA

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE (NAACP)
OPERATION PUSH
NATIONAL ASSOCIATION OF NEIGHBORHOODS
NATIONAL BLACK POLICE OFFICERS ASSOCIATION
POOR PEOPLE'S DEVELOPMENT FOUNDATION
CALIFORNIA INNER CITY FOOD COALITION
THE CENTER FOR NEIGHBORHOOD TECHNOLOGY
HARTFORD FOOD SYSTEMS, INC.
DENVER OPPORTUNITY, INC.
AGRICULTURAL MARKETING PROJECT (AMP) (Alabama, Tennessee)
OPERATION: GET DOWN (Detroit)
BOSTON URBAN GARDENERS, INC. (BUG)
HUNGER ACTION CENTER (Seattle)
UNITED PROGRESS, INC. (Trenton)
SOUTHEASTERN MICHIGAN FOOD COALITION
MAYOR'S COMMISSION ON COOPERATIVE ECONOMIC DEVELOPMENT
(District of Columbia)
MAYOR'S COMMISSION ON FOOD, NUTRITION AND HEALTH (District of
Columbia)
MASSACHUSETTS EXECUTIVE OFFICE OF COMMUNITIES AND
DEVELOPMENT, DIVISION OF SOCIAL AND ECONOMIC OPPORTUNITY
CALIFORNIA STATE INNER CITY FOOD TASK FORCE

Petitioners,

vs.

JIMMY CARTER, PRESIDENT OF THE UNITED STATES
ESTHER PETERSON, CHAIRPERSON OF THE CONSUMER AFFAIRS COUNCIL
BOB BERGLAND, SECRETARY OF THE DEPARTMENT OF AGRICULTURE
MOON LANDRIEU, SECRETARY OF THE DEPARTMENT OF HOUSING AND
URBAN DEVELOPMENT
PHILLIP KLUTZNICK, SECRETARY OF COMMERCE
NEIL GOLDSCHMIDT, SECRETARY OF THE DEPARTMENT OF TRANSPORTATION
G. WILLIAM MILLER, SECRETARY OF THE DEPARTMENT OF THE TREASURY
CECIL ANDRUS, SECRETARY OF THE INTERIOR
CHARLES W. DUNCAN, JR., SECRETARY OF ENERGY
PATRICIA ROBERTS HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES
SHIRLEY HUFSTEDLER, SECRETARY OF EDUCATION
RAY MARSHALL, SECRETARY OF THE DEPARTMENT OF LABOR
BENJAMIN CIVILETTI, ATTORNEY GENERAL
RICHARD RIOS, DIRECTOR OF THE COMMUNITY SERVICES ADMINISTRATION
ROWLAND G. FREEMAN, III, ADMINISTRATOR OF THE GENERAL SERVICES
ADMINISTRATION
SAMUEL BROWN, DIRECTOR OF ACTION
CAROL GREENWALD, PRESIDENT, THE NATIONAL CONSUMER COOPERATIVE
BANK
LAWRENCE CONNELL, CHAIRMAN OF THE BOARD, THE NATIONAL CONSUMER
COOPERATIVE BANK
A. VERNON WEAVER, ADMINISTRATOR OF THE SMALL BUSINESS
ADMINISTRATION

Respondents.

AN ADMINISTRATIVE PETITION
TO THE
PRESIDENT OF THE UNITED STATES, ET AL.

RE: IMMEDIATE EXECUTIVE ACTION TO ALLEVIATE THE NATIONWIDE INNER CITY FOOD CRISIS

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I.

INTRODUCTION

For low income inner city residents, the once simple task of buying food has become an ordeal requiring both ingenuity and fortitude. In contrast to suburban shoppers who have easy access to quality, competitively-priced food in well-stocked stores, residents of cities like Oakland, Detroit and Washington, D.C. are reminded daily by abandoned, boarded up supermarkets of their struggle to obtain life's essentials such as food. Isolated from thriving retail centers by both geography and prohibitive gasoline and transportation costs, inner city consumers are captives of expensive and frequently deficient corner markets. No matter where they are forced to shop, the struggle to obtain adequate nourishment is a test of survival.

In recent months, the combined pressures of double-digit inflation, soaring unemployment, and the continuing exodus of food chains from the inner cities have clearly had their most devastating impact on low income Americans confined to the nation's inner cities. Stated bluntly, there are now millions of Americans who lack even minimal access to decent food at affordable prices. The view of America as the land of plenty must not obstruct our recognition of a staggering food emergency which demands an immediate response.

In the petition which follows, representatives of low income consumers from inner cities across the country have joined to ask the President, his Consumer Affairs Council and all relevant agencies and departments to exercise immediately the skilled leadership and concentrated effort required to alleviate this crisis. Petitioners alert the President to a food crisis as devastating in its impact as any natural disaster, yet so unnatural in form that, without caring eyes, it can be overlooked.

Unlike a natural catastrophe, however, this emergency was humanly created and can be humanly solved.

As residents of the nation's inner cities will tell you, their very survival is at stake:

> "There are people in this community who don't know where their next loaf of bread is coming from anymore . . . . You've got to eat what you can find, whether it's fit for consumption or not . . . . Three meals a day went out the window years ago."
> (Statement by a resident of West Oakland, California)

> "I got to buy today so I'll have something left by Friday . . . . [explaining that if she used up all her resources early in the week and ran out of gas during the latter part of the week, it could prove disastrous]. When you come to Saturday and Sunday with nothing in the refrigerator, that's when the days get long." [1]
> (Statement by a woman in Harlem)

> "They really do have to do something about this inflation . . . . Prices are just too high . . . . Sure I get angry. But I get angry at myself because I know there are things the kids need and I can't afford them."
> (This from a Chicago mother who often went to bed hungry while pregnant so that her children could be fed. Her daughter, now three, was born with a cleft palate and webbed fingers, which her doctor attributes to insufficient nourishment in the fetal stage) [2]

> "The smallest stores don't stock most of the things you want. The ones that do have prices so high you can't afford to purchase the items. Any store that even begins to have the things you want at reasonable prices is two bus rides away. You can't do any serious shopping without the expense of a taxi cutting into your food money."
> (Statement of a shopper in Watts)

Already the early warnings of Miami, Chattanooga and New Orleans have indicated that conditions in our inner cities are truly severe. The leadership of this country must not await the traditional distress signal from beleaguered inner city residents: riots. The President can and must act now to develop and implement mechanisms which insure adequate availability of food to the grievously neglected inner cities. Petitioners seek from the President and his administration emergency actions both to halt any further deterioration of inner city food access and to begin the immediate reindustrialization of those inner cities already abandoned. Accordingly, petitioners request that the President and his administration undertake immediate action on two fronts:

Front One: Immediate Preservation Plan

Under the authority granted by the Stabilization of the Economy and Commodity Prices Act (1947) (50 App. U.S.C. § 1911, et seq.) the President shall implement a Preservation Plan to maintain existing markets in "food crisis zones," the inner city areas most severely affected by food shortages. This plan will, at a minimum, provide for advance notification to the community of store closings, provide community organizations and the affected city the right of first refusal on the purchase or lease of the closing markets, and through federal assistance enable such purchases and leases to occur.

Front Two: The President's Inner City Food Reindustrialization Team/Reindustrialization Summit Conference

Contemporaneously, the President, working with his Consumer Affairs Council, will activate the Inner City Food Reindustrialization Team, a working group comprised of selected representatives of low income community groups and relevant officers of the public sector on local, state and federal levels. Immediately following their appointment, the President will convene a Reindustrialization Summit Conference, at which time the Reindustrialization Team will initiate mid- and long-range self help solutions to the inner city food problem. The Consumer Affairs Council, established by Executive Order 12160, will coordinate the Team to insure that this complex problem, which does not fit neatly into any single agency's jurisdiction, is solved in an integrated and expeditious manner. (These remedies are more specifically described in Section VI, infra.)

II.

PETITIONERS

THE NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE (NAACP)

The NAACP was founded 71 years ago by a group of earnest and uncompromising men and women who believed in the democratic process to ensure equal opportunity for all. The NAACP is the oldest and, with some 500,000 members and 1700 chapters across the country, the largest organization of its kind.

OPERATION PUSH, INC.

Operation Push, Inc. is an Illinois non-profit corporation whose purpose is expressed in the acronym Push, meaning People United to Serve Humanity. Operation Push was officially founded in 1971 as a national human rights organization with a civil-economic thrust directed toward equity and parity for all, particularly Black, Hispanic and poor people. The overall Push program focuses on self and community motivation and social responsibility to overcome the atmosphere of mediocrity, cultural decadence and dependency presently obstructing the objectives of the civil economics movement.

NATIONAL ASSOCIATION OF NEIGHBORHOODS

The National Association of Neighborhoods (NAN) represents over 500 organizations and coalitions from neighborhoods across the country. Formed in 1975 to educate the public about the neighborhood movement and advance the interests of neighborhoods, NAN also operates technical assistance programs for neighborhood groups.

In 1979, NAN convened the National Neighborhood Platform convention. Local platform conventions, involving over 10,000 participants, were held prior to the National Convention. There, 700 delegates drafted and adopted a National Neighborhood Platform, an action agenda for neighborhood groups. Displacement, or "the calculated efforts of large corporations, banks, real estate and utility contracts with the cooperation of the federal government, to bring about the wholesale racial and economic resegregation of the cities of this country" emerged as the priority issue of the convention. Displacement is manifested by the destruction of basic community services including food distribution systems. The National Neighborhood Platform is a testament to the ability of neighborhood organizations to organize democratically, voice their concerns, and work jointly to strengthen their communities.

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NATIONAL BLACK POLICE OFFICERS ASSOCIATION

The National Black Police Officers Association is the professional organization of Black police officers across the country. Patrolling the inner cities of the nation by foot, horse and motorized vehicles, these police officers are fully aware of the exodus of the major food chains and the resulting crisis in food distribution. The Association recognizes a special responsibility to the residents of the inner city and therefore seeks immediate executive action to assist in the development and implementation of self-help solutions to the inner city food crisis.

POOR PEOPLE'S DEVELOPMENT FOUNDATION, INC.

Founded in Resurrection City during the Poor People's Campaign of 1968, the Poor People's Development Foundation, Inc. (PPDF) strives to promote the health and social welfare of impoverished Americans through community cooperative economic development. It assists poor people in creating new industries, business enterprises, credit unions and housing projects by providing technical assistance funds, training programs, and access to other available resources. PPDF believes that through the development of community-based cooperative enterprises, low income neighborhoods will not only be able to provide themselves with the goods and services they require, but will also provide themselves with a local, independent source of income to finance much needed social programs. These cooperatives will also benefit the community by creating additional jobs, resulting in reduced unemployment and alleviation of some of the most dire effects of double-digit inflation.

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Oakland, San Francisco, Los Angeles

CALIFORNIA INNER CITY FOOD COALITION

In the Fall of 1979, 14 community-based organizations* representing inner cities throughout the state of California successfully petitioned Governor Brown to respond to the inner city food crisis. As a result of the coalition's efforts, Governor Brown established an Inner City Food Task Force staffed by cabinet level government officials. The Task Force has worked directly and effectively with industry and community organizations to implement statewide inner city programs which are community controlled and which effectively fill the void created by the exodus of food chains. Community-based organizations in Watts, West Oakland and the South of Market area of San Francisco are preparing to open community cooperative markets which have received acclaim statewide. Farmers' markets opened this summer in inner city communities in Los Angeles, Oakland and Sacramento.

Chicago

THE CENTER FOR NEIGHBORHOOD TECHNOLOGY

The Center for Neighborhood Technology is a non-profit technical assistance center assisting Chicago community groups in making their neighborhoods more self reliant in food, energy, shelter and waste management. Since 1977 the Center has assisted community groups establishing community solar greenhouses, alternative food distribution systems (co-ops, farmers' markets), energy conservation and recycling projects.

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* Oakland Citizens Committee for Urban Renewal (OCCUR), The East Los Angeles Community Union (TELACU), Organization for Black Community Development (OFBCD), West Oakland Food Project, Earthwork, Our Lady of Soledad Parish, Glide Memorial Methodist Church, Bay Area Urban League, Interfaith Hunger Coalition, Community Care and Redevelopment Services, The Afro-American Cultural Education Center, Inc., Tenants and Owners Development Corporation (TODCO), Group for Action in Nutrition (GRAIN), San Francisco Gray Panthers, and Booker T. Washington Child Development Center.

Hartford

HARTFORD FOOD SYSTEMS, INC.

Hartford Food Systems, Inc., founded in 1978 is an evolving network of self-help programs designed to provide an opportunity for Hartford residents, two-thirds of whom are low income, to participate directly in the production, processing and distribution of high quality, low cost food. In four target inner city neighborhoods, the System successfully initiated 450 community gardening plots, several farmers' markets, a community self-help cannery, a solar greenhouse, and a vocational agricultural program at the public high school.

Denver

DENVER OPPORTUNITY, INC.

Denver Opportunity, Inc. is the anti-poverty agency serving the City and County of Denver, Colorado which has an estimated 75,000 residents living at or below poverty level. The agency's Community Food and Nutrition Program, traditionally strong in its advocacy efforts, has recently begun establishing food preservation centers for canning and solar dehydration and developing farmers' markets. The program also assists the Metro Food Bank Coalition and is working to preserve or restore supermarkets in inner city areas.

Tennessee, Alabama

AGRICULTURAL MARKETING PROJECT (AMP)

Since 1975 the Agricultural Marketing Project (AMP) has organized farmers' markets to promote systemic change in the food distribution system. Emphasizing small farmer control, consumer participation, decentralization, local marketing and energy conservation, farmers' markets called "Food Fairs" have been set up throughout Tennessee and Alabama, providing a model for similar successes in North Carolina, Georgia, Ohio and Mississippi. There are now Food Fairs operating in 20 Tennessee cities including Memphis and Nashville and 19 cities in Alabama including Mobile, Selma, Montgomery and Birmingham.

Detroit

OPERATION: GET DOWN

In 1970 a group of concerned Detroit residents organized themselves to combat the serious problems then facing their community including food distribution, health care, housing, education and crime. The result was Operation: Get Down. Committed to the concept of self-help, the organization has implemented a variety of programs including the establishment of the Detroit Food Program, operated by Get Down under contract to the City of Detroit. Originally a prepaid, pre-order buying club serving fifty families, it has grown to include over 500 households, serving upwards of 15,000 people. Today it is the largest urban food buying club in the nation, working out of nine inner city locations and through member participation offering 30-50% savings on food purchases.

Boston

BOSTON URBAN GARDENERS, INC. (BUG)

Boston Urban Gardeners, Inc. (BUG) is a non-profit organization comprised of community garden groups, agency staff, and community residents who are interested in urban agriculture and community economic development. BUG has catalyzed the development of 120 community gardens in Dorchester, Roxbury and the South End, neighborhoods in dire need of alternative food delivery systems. BUG has always been innovative -- from its persuading the National Guard to haul topsoil donated by the Metropolitan District Commission to proposing recently adopted legislation for the state of Massachusetts to purchase fruit and nut trees for planting on vacant state-owned land.

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Seattle

HUNGER ACTION CENTER

The Hunger Action Center of Seattle, Washington is a non-profit corporation devoted to combatting that state's food and hunger problems. One of its most important accomplishments was leading the repeal of Washington's sales tax on food. Realizing that families who made between $5,000 and $6,000 a year spend 22% of their income on food, the Center helped form a coalition of more than 50 senior citizen, consumer, and child welfare groups to repeal the tax. Four years after the Hunger Action Center's initial lobbying of the state legislature, the citizens of Washington approved the initiative which now saves low income consumers approximately $142 on their yearly food bills.

Trenton

UNITED PROGRESS, INC.

United Progress, Inc. (UPI) is the federally funded anti-poverty agency serving the city of Trenton, New Jersey. The city's population of 90,000 is two-thirds Black and Hispanic, and most residents are working poor or on fixed incomes. The agency operates in all of Trenton's wards and has many components, including child care, CETA training, social services and meals-on-wheels programs. Quality food is inaccessible to the majority of Trenton's residents. The agency seeks durable solutions to supplant existing food giveaway programs that frequently are insufficient to meet demand.

SOUTHEASTERN MICHIGAN FOOD COALITION

The Southeastern Michigan Food Coalition (SEMFCO) is an interfaith, non-profit organization created in 1977 to address the need for a comprehensive approach to local hunger and nutrition issues. It is comprised of concerned individuals, religious groups, hunger activists, low income consumers, rural advocates and community organizations from throughout a seven county region. This seven county region includes over half of Michigan's population who live below the poverty line, most of the state's minority population, and a large percentage of senior citizens -- groups most severely impacted by the inner city food crisis. Through its staff and task force, the Coalition serves as an umbrella organization and as a catalyst for action. Over the past year, the Coalition has initiated an examination of Michigan's entire food system, and has been involved in bringing together the food industry, low income consumers and farmers to discuss the development of joint ventures.

District of Columbia

MAYOR'S COMMISSION FOR COOPERATIVE ECONOMIC DEVELOPMENT

The Mayor's Commission for Cooperative Economic Development was recently established to promote cooperative development as as economic alternative for the District of Columbia, particularly for low and moderate income residents. The Commission includes representatives from: District-based consumer cooperatives; appropriate D.C. government agencies, financial institutions; and local neighborhood organizations.

The Commission is authorized to conduct feasibility studies, provide advice on organizing and financing cooperatives (in conjunction with the National Consumer Cooperative Bank wherever possible), maximize local neighborhood participation in establishing cooperatives and initiate programs to provide technical assistance. The present food distribution crisis in Washington has prompted the Commission to make food cooperatives a top priority.

District of Columbia

MAYOR'S COMMISSION ON FOOD, NUTRITION AND HEALTH

The Mayor's Commission on Food, Nutrition and Health was established after the White House Conference on Nutrition in 1969, to improve the health and well-being of Washington, D.C.'s population, particularly its low income residents. Composed of both community representatives and professionals in the field, the Commission advises the Mayor, promoting nutrition education programs and adequate food distribution systems. The Commission is particularly active in the fight to decrease Washington's high infant mortality rate and was instrumental in assisting various community groups to establish a food bank for the city's metropolitan area and a farmers' market.

MASSACHUSETTS EXECUTIVE OFFICE OF COMMUNITIES AND DEVELOPMENT, DIVISION OF SOCIAL AND ECONOMIC OPPORTUNITY

The Division of Social and Economic Opportunity is the branch of Massachusetts state government designated to carry out programs attacking the problems of poverty. Beginning in 1976, the Division's Executive Office of Communities and Development has run the MASSfood program (for "Massachusetts Alternatives toward Self-Sufficiency in Food") funded by the Community Services Administration. MASSfood supports community based solutions to high food prices. MASSfood has funded the construction of the state's first two community greenhouses (in Fall River), a multiple-site community gardens project (North Shore), and a comprehensive seed-to-table education/outreach project (Northhampton).

Another successful effort was the "MassSeed" program which, by providing free seeds for low income gardeners, nearly tripled the number of low income community gardeners in the state, from 4,000 to 11,000. With an average garden yielding $90 worth of produce, the state's low income gardeners have saved $1,000,000 annually. In light of such success, the Massachusetts Department of Food and Agriculture was persuaded to take over the entire cost of providing the free seed. MASSfood is now building support for a statewide chain of food banks which will receive large supplies of donated surplus food to distribute to non-profit programs.

CALIFORNIA STATE INNER CITY FOOD TASK FORCE

The California State Inner City Food Task Force is an executive entity created by Governor Brown, headed by officials of the State and Consumer Services Agency and composed of representatives from a cross-section of state agencies. These agencies include the Departments of: Consumer Affairs, Economic and Business Development, Business and Transportation, Food and Agriculture, Finance, Employment Development, and Social, Health and General Services.

The purpose of the Task Force is to create a state/citizen structure actively seeking means of addressing the inner city food crisis through the coordination of government, private industry and community orgaizations. As a direct result of the Task Force's efforts within the past year, ten farmers' markets and three major food cooperatives will hve opened in California's hardest hit inner cities: Watts, the South of Market area in San Francisco, and West Oakland.

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III.

STATEMENT OF FACTS

A. The History of Deteriorating Inner City Food Distribution

Certain economic and political forces, coupled with a lack of decisive and coordinated action by the federal government have led to the present nationwide inner city food crisis. Access to wholesome foodstuffs at reasonable prices was not difficult for urbanites twenty years ago, when dozens of small groceries owned and operated by local persons and independently-owned regional chains served inner city communities.[3]

In the 1960's and 1970's, however, national food chains began their drive to take over a larger portion of the food market by buying out competing stores and local chains.[4] A 1972 survey of urban areas found that the four largest grocery retailers held approximately 52% of the sales -- a degree of economic concentration generally conceded to diminish price competition.[5]

Chain stores captured even greater percentages of the market share in low income urban areas by charging lower prices than their small and independent competitors. Even so, the chains still charged more to their inner city customers than to their suburban clientele.[6] These nationwide chains, often vertically integrated from farm to supermarket shelf, easily shifted losses to other divisions of their operations and used this economic power to undercut the local independent grocers.[7] Employing price wars, the chains effectively drove the competition out of business and increased their profits dramatically.[8] As a consequence, low income consumers came to rely more heavily on the national food chains. No sooner had this dependence been forged when the supermarket chains themselves began abandoning the urban communities to concentrate on their relatively more profitable suburban stores. Nationwide, this exodus has been severe. In 1967 there were about 185,000 grocery stores run by 300 chains (11 or more stores) in America's inner cities. By 1975, the number was down to 155,000, a drop of 17%.[9] During the past 10 years, the number of stores in Boston, Washington, D.C. and Chicago has declined between 28 and 50 percent.[10] In certain cities, the drop has been particularly precipitous. A USDA study in Washington, D.C. revealed that in 1968 four chains operated 91 food stores, but by 1978 only two major chains were operating 41 stores.[11] This devastating trend continues.

The national chains explained their flight from the inner city with elaborate studies of the high cost of doing business in low income areas, including high rents, high insurance costs and rapid labor turnover.[12] The supermarket chains also asserted that low profit margins of 1-2% contributed to the exodus. Such figures, however, are misleading since the chains receive that return after each turnover in inventory, which occurs in this industry approximately once a month.[13] Furthermore, many of the high costs of doing business -- warehousing, paying suppliers, and transportation -- are generated by other divisions of these vertically integrated food corporations, divisions whose profits are not reflected in the claims of only 1-2% profit margins.[14]

High costs and low sales volume are not the only causes for the abandonment of the inner cities. Corporate planners have simply decided that it is more profitable and convenient to operate large food stores elsewhere.[15]

In the wake of the food chain exodus, low income consumers must fend for themselves. They are left to choose their evils. Some travel by expensive and inconvenient public transportation to still existing chains on the fringes of their neighborhoods. For the handicapped, elderly and parents with young children this alternative poses insurmountable difficulties and dangers. Private transportation is clearly out of the question: of those low income persons participating in a 1975-76 Washington Urban League Poll who said there was no supermarket within four blocks of their home (over half the total), 70% said they did not own a car and 63% said they usually must wait at least 30 minutes for a cab, which they could not afford.[16] Indeed, a fleet of gypsy taxi drivers has begun to flourish in inner cities on the days welfare checks arrive, transporting shoppers home with their twice monthly purchases.[17]

Others shop at local small corner stores which typically stock a few low quality items and sell them at exorbitant prices. Neither course of action is satisfactory, but the low income family has no choice. To an outside observer, the lack of food stores may not present the urgency of war time, but to the inner city resident, inadequate food availability is a very real threat to existence.

The descriptions which follow are of cities which typify the communities represented by petitioners, and give a brief glimpse of the severity of the inner city food distribution crisis.

A MICROCOSMIC VIEW OF THE PROBLEM

West Oakland, California

Liquor stores are the most numerous of the few remaining businesses in West Oakland. Main streets are lined with abandoned buildings -- broken windows and "We're Closed" signs are everywhere. The unavailability of basic necessities and the lack of community institutions have driven thousands of people out: the population dropped 33% between 1970 and 1977 to 19,734.[18] Eight-eighty percent of the population is Black.[19]

A cluster of large federally funded housing projects surrounds one of the three groceries that the West Oakland community currently relies on for food. Several senior citizens homes dot the area. Most residences are old, but well kept. At night the streets are poorly lit and deserted.

Bounded entirely by freeways,[20] the three and one-half square mile area is cut off from the retail centers of Oakland. "We're boxed in," said one long time resident. The area is bordered by downtown and North Oakland, another poverty-stricken section.

The people of West Oakland are poor. More than 50% of the residents are classified as living below the poverty level, and more than one-third receive Aid to Families with Dependent Children payments and/or food stamps.[21]

Isolated, but not self-reliant, West Oakland continually struggles for survival. The crisis in inner city food distribution has hit this area hard, and is a central factor in its deterioration. The people are forced to depend on one medium sized supermarket (14,000 square feet) and a few small groceries (one at 8,000 square feet and one at 3,000 square feet). Most modern supermarkets are over 20,000 square feet. Recently, through community initiative, one food cooperative has begun.

Prices in these stores are exorbitant compared with prices in other Oakland supermarkets, and owners charge extra for check cashing and other services. In 1979 when an informal survey was conducted, chicken wings sold for $.79/lb at a supermarket 10 blocks northeast of West Oakland but went for $1.09/lb at the local West Oakland grocery. Dried kidney beans were bought for $.59/lb across the freeway, but ran $.79/lb in the local store. Crisco shortening was 20% more expensive within the community. None of the existing West Oakland stores carry a variety of fresh fruits and vegetables, and the little produce available is of very poor quality.

Some residents attempt to escape this price squeeze by walking downtown to other food retailers. But construction of the Grove-Shafter freeway has made this trek even longer: a 10-block area between the downtown area and West Oakland has been fenced off, closing it to pedestrians.

Upham's Corner: Boston, Massachusetts

When First National Supermarkets (Finast) closed 52 markets in Massachusetts and Rhode Island -- with four days' notice -- this past July, a leading author for a supermarket trade paper stated that most of Finast's former business would go to other nearby stores.[22] Yet for many poor neighborhoods, nearby stores are non-existent.

One such neighborhood is Upham's Corner in Boston. The Upham's Corner Market, which was closed a year and a half ago, was the first supermarket in the county and central to the area. Then, with July's closing of the Morrisey Boulevard Finast Store, Upham's Corner residents lost their last nearby market. Now the 15,000 residents of this inner city neighborhood have a choice of three markets, but each is three miles away in different areas of the city.

Upham's Corner is a poor, ethnically diverse area with Black, Hispanic and Cape Verdean residents along with a smaller number of people of Irish and Canadian descent. It is a stable community, with an elderly population of 20%. 1970 Census data indicated that one quarter of the residents earned less than $5,000 annually, many of whom support large families.

The business district in Upham's Corner is sagging. The empty Upham's Corner Market only accentuates the other deteriorating store fronts and 42 vacant buildings in the area. Businessmen are apathetic, and residents are discouraged and confused. "I don't understand," said one long time resident. "Are they deliberately trying to run down the neighborhood?" The $2 million poured into the community to rehabilitate the area's once famous Strand Theatre did not draw the supermarkets back into the community. Instead, local residents pay out a $4.00 cab fare each time they go shopping at the nearest market.

The situation remains bleak. Not long after the closure of 52 of Finast's 63 New England stores, a local food company announced plans to reopen 24 of them. For Upham's Corner residents it came as no surprise that none of the several Boston neighborhood stores, including their own, was among those to be reopened. Despite community need and some visible solutions to the problem elsewhere in Boston, Upham's Corner, like so many other poor neighborhoods across the nation, lacks the start-up money, expertise and support needed to successfully adapt such models to their own community.

Detroit, Michigan

Thirteen years after the riot of 1967, Detroit neighborhoods still resemble war torn zones. With over 7,000 abandoned storefronts, with the closure of the giant auto plants on the East Side, and with less than 30% of the downtown area utilized for commercial and industrial activities, this once bustling city is now an urban wasteland. Continuing demolition of dwelling units and commercial buildings, often for the sole purpose of reducing tax assessments, has increased the number of rubble-strewn lots which contribute to Detroit's general deterioration and decay.

The food situation in Detroit is disastrous. The Twelfth Street/Virginia Park area, about one mile square, is without a single food store despite a large and needy population. Near the downtown area on Cass Corridor where large concentrations of senior citizens live on fixed incomes, no competitively priced large selection chain stores exist. Farmer Jacks supermarkets are located near only two of Detroit's many public housing projects; other housing project residents who lack transportation must shop at local small grocers. These small corner stores are not an adequate substitute when it comes to major food purchases, for they are heavily stocked with alcoholic beverages and snack items rather than nutritious foods. When the markets do carry fresh produce or staples, the selections are extremely limited, quality is often poor and prices are exorbitant.

Residents of Detroit can ill afford either expensive transportation to lower priced stores in outlying suburbs such as Warren or Birmingham, or high priced foods available locally. The latter is no alternative for these residents who already are experiencing Detroit's double-digit food inflation.

The city's poor, who are hardest hit by the supermarket exodus, are growing in number. As of July, 1980, 18.3% of Detroit's residents were unemployed. Numbers of persons on AFDC rose 36% during the past year; the increase during the same period for those receiving food stamps was 39%. Emergency food programs have been swamped.

The Black community which makes up a majority of Detroit's population has made several attempts to improve food access, but it has met with limited success. Attempts to increase the 1% Black ownership of supermarkets has been stymied by lack of start-up capital and lack of financial assistance from either local banks or wholesalers. Food buying clubs have been initiated and networks of clubs are springing up. Nevertheless, the situation in Detroit remains bleak.

Washington, D.C.

> "We live in a housing project on 11th. The nearest supermarket chains are at 11th and Florida, 14th and Packwell and the Giant on 9th. That's where we have to shop because the local corner store is out of business again. The closest corner store is on Sherman Avenue, four blocks away, and carrying groceries even from there is a problem. But all the markets are too far to walk to for senior citizens and a lot of them live

in this area."

(Statement from a resident
of Northwest Washington, D.C.)

Large numbers of senior citizens live throughout the city of Washington. While the overall population of the city has declined in the past ten years, the numbers of poor and elderly continue to grow. These are the people most severely impacted by the exodus of food stores. It is the unfortunate reality that those areas of Washington with the greatest number of stores leaving are also the areas with the highest incidence of poverty and with the least access to suburban Maryland where many of the chains have relocated. More than half of the elderly single renter households in D.C. have incomes of less than $5,000; 37% of D.C. renters pay 25% or more of their income for rent. Taken together, it is clear that Washington's residents can ill afford the choice between purchases of locally available high priced food or travel to suburban markets, given their bare-bones food budgets.

From 1968-1975, there was a 33% decrease in food store facilities in the city, with even higher losses in certain neighborhoods. The trend continues unabated. Giant, one of Washington's large chains, has begun to open no-frills stores, but for the most part, they are located in the suburbs. In the city, there are over 90 census tracts without large food stores. Those areas which have supermarkets are terribly underserved. In Anacostia, with more than 165,000 residents, there are only five full-sized supermarkets.

Without local stores which are affordable, transportation becomes essential. A Southeast Washington resident commented: "The nearest chain store is seven blocks up . . . . It's a hardship to carry all those packages seven blocks -- most don't have cars." As a consequence, "Do you have a way home?" has become a common refrain heard by low income shoppers emerging from existing supermarkets on the first of every month. Without private transportation, residents must depend on gypsy cabs to take them home with their four and five bags of groceries. These gypsies charge less than licensed cabs and eliminate the futility of attempting to reach home by bus. Aside from being inconvenient, buses seldom travel cross-town, routes that are essential for the city's shoppers. So residents depend on gypsy cabs which eat up any savings they achieve by shopping at the chain store.

It is a sad commentary that in the shadows of the nation's capitol there is a deepening food crisis that goes unrecognized except by the residents who lack resources to cope with the problem themselves. Although community residents have taken the initiative to begin operating food cooperatives, residents need greater assistance and a wider range of alternatives. One resident whose sentiments are shared by many in the community, declared, "Something has to be done. I see kids get maybe one or two nutritious meals a month."

B. Factors Contributing to the Food Emergency

In addition to the abandonment of the inner cities by nationwide food chains, other current economic factors have aggravated the ever-worsening food crisis. The already minimal food purchasing power of low income persons has been even more drastically eroded by double-digit inflation for the necessities of life (up 17.6% in 1979), an unemployment rate of 7.6% nationwide, a continuing energy crisis, and a widening chunk of the food dollar appropriated by mid-level distributors (62% in 1974). These harsh economic conditions have forced low income families to respond by squeezing the only variable in their already subsistence level budgets -- food.

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The Impact of Inflation

The spiraling inflation rate for the basic necessities, while difficult for all consumers, works a particularly harsh injustice in inner city communities where competitively priced food is inaccessible. During the first three months of 1980, the cost of the basic necessities -- energy, housing, food and medical care -- rose 23.7%, more than double the 11.5% seasonally adjusted rate for all other items in the government's consumer price index. Thus, the trend of a virtual explosion in the price of necessities continues; in 1979 while the annual inflation rate averaged 13.3%, necessities of life rose 17.6%.[23] As a recent study reported, "For real people trying to make wages meet expenses, inflation is much worse in the things we have to buy than the things we can postpone. Energy, food, housing and health care make up two-thirds of the household budget for 80% of American families."[24]

Obviously, the poor must spend proportionately more of their incomes for these necessities. Low income families allocate over 40% of their incomes to food alone. A 1975 Federal Trade Commission staff report succinctly described this regressive impact:

> "Food price increases are felt directly by all consumers, but they bear particularly heavily on low income groups, large families, older people on fixed incomes, and the unemployed. These are groups that spend a proportionately higher percentage of their income on food and can least afford to have to increase their food budgets. The fact that the higher prices came at a time of increasing unemployment and deepening recession has added greater stress." [25]

Even within the essentials, there has been a disproportionate rise in the cost of lower priced basic foods and goods. Whereas middle income consumers have the option of "spending down" and purchasing less expensive essentials, low income families are already buying the least costly items. For example, according to January 1980's CPI, hamburger increased 33.5% from 1978 to 1979, as compared with a 21.6% rise in sirloin steak. The cost of pasta products, which consumers traditionally turn to in times of high meat prices, is expected to rise sharply in the coming months; the price of durum wheat has already climbed 60% since June.[26]

Similarly, if low income persons own a vehicle at all, they own older, used models. In contrast, middle income persons can frequently purchase new fuel-efficient cars which will ultimately save them a significant amount in energy costs.

Improvements in the CPI's housing index are also deceptive. They reflect drops in mortgage interest rates and declines in housing prices, neither of which impact directly on the overwhelming number of inner city dwellers who are renters. As one economist remarked after the July, 1980 CPI figures were announced,

> "Obviously, the increase in food prices is more significant than the decrease in housing costs . . . . People go to the supermarket every week; they may buy a house once every seven or eight years. Less than a million people a year might be affected by mortgage costs; everyone feels the bite of higher food bills."[27]

For those low income persons who rely on government maintenence programs, the situation is even worse, and the number of persons who must rely on such programs is increasing. Nearly eight million Blacks now live below the government's poverty line compared with seven million eleven years ago.[28] A recent briefing issued by the USDA emphasizes that one consequence of soaring inflation is an influx of persons entering the low income bracket and concomitantly requiring assistance from social programs slated for cutbacks. The report stated:

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> "New participants [an additional 3.5 million persons in the Food Stamp Program since it was amended in 1977] are poorer than expected, with most of these households having gross incomes below $3,600 a year. This poverty shows signs of worsening as food stamp recipients fall behind other Americans in the effort to keep pace with inflation. While the overall average income of Americans has gone up 40% in the past four years -- slightly ahead of the 30% cost in living -- the incomes of food stamp users rose by only 7% in this period." [29]

Many federal programs like welfare assistance are not indexed to keep pace with inflation, and thus, despite some increases in benefits, families have less to spend today in real terms than they did a few years ago. As recently reported in the Wall Street Journal, the New York City basic welfare grant, established in 1974, allocates $14 a month for gas, electricity and telephone combined. Yet today's average electricity bill alone is $31.00.[30] Thus runaway inflation grossly magnifies already significant disparities in income distribution. Without any fat to cut from their budget, inflation forces the low income family to spend a disproportionate amount on essentials, ranging from 70 to over 100 percent of their household budgets.

The Impact of Energy Costs

The soaring price of energy has exacerbated the food distribution crisis in three distinct ways. First, higher production and distribution costs make food more expensive. In the past decade, food production has grown more energy intensive and there is an increasing emphasis on processing and packaging, requiring vast amounts of energy consumption. There has also been a shift away from local distribution systems toward a national distribution network which requires hauling over great distances and results in high refrigeration costs. Accompanying this has been a shift from energy efficient railroads to energy guzzling trucks.

Second, given the flight of supermarkets from low income neighborhoods, transportation has become increasingly critical for these consumers. Yet, the cost of traveling to still existing chain stores has become prohibitive. Private transportation is virtually non-existent in these neighborhoods and public transportation is equally unfeasible given skyrocketing fares and inherent inconvenience. It is a troublesome task for anyone to ride the bus with bags of groceries in tow, but such excursions are next to impossible for those with young children, the handicapped, and the elderly. As one Philadelphia resident recently stated:

> "Unless you have a car, you have to shop at a store close to your house. Only about half the people have cars in this neighborhood, and if a family does happen to have a car they have to use it to get to work. People would use public transportation but you can't even take shopping carts on the bus -- they aren't allowed. The only alternatives left are the corner stores which are higher priced. The supermarkets which remain are too far to walk to and for seniors, walking is often their only means of transportation." [31]

The upward spiral of energy costs has also had the effect of cutting ever further into the low income family's subsistence level food budget. A recent report by the Department of Energy's Fuel Oil Marketing Advisory Committee indicated that low income families are now spending 21% of their income in utility bills, compared to 5.1% for middle income families.[32] These utility bills are fixed costs which must be paid on a regular basis. Food, therefore, is the only necessity which offers some flexibility, and becomes the one item which cushions the impact of other continuing economic blows.

The Impact of Unemployment

Low income inner city residents cannot compensate for the effects of inflation on the basic necessities with commensurate increases in income. The current recession has hit low wage workers first and most severely in the form of deepening unemployment. Today, while the nationwide unemployment rate hovers at 7.6%, the unemployment rates in cities are staggering: Toledo, 13.7%, Chattanooga, 9.4%, Huntsville, 10.1%, Newark, 8.0%.[33] Black unemployment nationwide is 12.6%, nearly double the unemployment rate for Blacks in the 1960's, and twice the current unemployment rates for whites.[34] Even those who have been fortunate enough to retain their jobs have not thereby gained immunity from the effects of the recession. They suffer from losses in overtime and reductions in their normal work week. Maintaining one's ground is now a struggle; any thought of job advancement is out of the question. Unemployment benefits fail to cushion the grim situation for the low income families since benefits are not indexed to keep pace with inflation, and many of the unemployed are simply not eligible under program guidelines. A survey conducted in 1976 by the Bureau of Labor Statistics found that seven out of 10 of those sampled were meeting their living expenses by cutting back on food and other essentials.

Unemployment-related stress also takes its toll on the health of these workers, further compounding the already serious health consequences resulting from a lack of adequate, reasonably priced food.[35] Despair and anger are growing. A Wall Street Journal reporter, surveying the economic conditions on the South Side of Chicago, interviewed one woman with a three-month old infant at an employment center. She said, "I don't want to go on welfare. I want to get me a job. But if I can't get enough money to feed my baby, I'm going to steal it."[36]

Food: The One Escape Valve

There is desperation in America's inner cities, for low income people simply cannot tighten their belts any further.

Inflation has eroded their buying power, especially of essentials. Energy costs consume an ever growing portion of their subsistence budgets, and greater numbers of the inner city poor have joined the legions of unemployed seeking assistance from programs slated for drastic cutbacks.

Food is the only escape valve for these present economic pressures. Low income persons must pay rent, pay utilities, and pay for transportation to get to work. They already restrict their fuel consumption and obtain only the most necessary medical care. Only the food budget alone can be trimmed, and for the poor this has gone well beyond trimming off the fat. A welfare advocate poignantly translates what this means in human terms:

> "On September 4, a woman with an infant called me from a phone booth near her apartment in South Central Los Angeles. Because of a dispute with the welfare office (which she has now taken to fair hearing), she has only been able to receive Aid to Families with Dependent Children for the child and not herself. Consequently, she receives $200 a month plus $60 a month in food stamps. When the baby was born in August, her rent was increased from $155 to $185 a month. She has a running debt with the utilities company because she never has enough to pay the full bill. All she has left for food is $60 a month in food stamps, and she regularly trades some of these with neighbors for diapers and soap which she cannot afford to buy. The food she does buy comes from a small store around the corner from her apartment. She admitted that the prices were high, but said she found it too difficult to carry the baby and the groceries on the long bus ride to the supermarket.[37]

C. The Social, Health and Economic Costs

A grave economic injustice exists when, in this agriculturally rich nation, inner city residents are suffering from chronic undernutrition caused in significant part by the unavailability of fresh fruits and vegetables, the poor quality of meats, fish, and poultry, and the exorbitant costs of all food.

It has been estimated that in Chicago's South Side alone, almost two-thirds of the residents suffer from poor nutrition. Ann Hammond, University of Illinois nutritionist, has noted that due to high food prices, low income residents are eating too much starchy, filling foods and insufficient amounts of meat and fresh vegetables.[38] These inequities exact a toll in health, opportunity and increased government spending which is well documented.

Unquestionably, the result of poor nutrition is bad health. Faulty nutrition leads to increased infant mortality and maternal morbidity; it stunts development, both physically and mentally, and it predisposes people to or aggravates a spectrum of disease conditions, diminishing the quality of life, personal productivity and longevity. As one Pontiac, Michigan resident commented:

> "As a diabetic, I am not afforded the opportunity to get the fresh meat and vegetables I need for my special diet due to the lack of good public transportation and good quality stores. There are only two chain supermarkets here in a city of 80,000. This means that I end up spending 15-30 days a year in the hospital suffering from diabetic attacks, mainly due to not being able to stay on my prescribed diet."

The poor diet available in the inner city is a major contributing factor to the high frequency of troubled pregnancies, notably low birth weights, still births, neonatal deaths, and birth defects.[39] The consequences are vividly seen in American infant mortality rates. While the 1977 infant mortality rate for the U.S. was only 15.1 per 1,000 births, the rate was 35.9 in Central Harlem, 22.1 in Watts and 26.3 in East Oakland.[40] Even if the child survives birth, nutritional imbalance during infancy and childhood may produce severe and prolonged effects. For example, the nervous system, which continues to develop after birth, may be damaged by early nutritional deprivation.

This damage may take the form of mental or behavioral abnormalities.[41]

Major nutritional problems are most prevalent in young minority group individuals of low socio-economic status.[42] Poor nutrition, in turn, affects a child's learning capabilities. Specifically, iron deficiency anemia, which is common among Mexican-American children and low income Black and white children, contributes to decreased ability to concentrate and thereby interferes with learning.[43]

Indeed, the social consequences of poor food distribution are far reaching. In testimony before the U.S. Senate Committee on Agriculture, Nutrition and Forestry in 1978, Dr. Raymond M. Wheeler stated:

> "It is important to understand that the effects of inadequate food, bad housing and poor medical care are not confined to the poor, but directly determine the strength and vitality of our society, the amount of wealth we produce, and the incomes we enjoy. More than ten years ago the Office of the Budget calculated that for every dollar we failed to spend feeding hungry people, it costs our government over $3.00 in payment of sickness, care, lower productivity and so called hand outs to the disabled. I suspect that the figures are equally or even more applicable today."

Barry M. Popkin of the University of Wisconsin's Institute for Research on Poverty estimates that the total economic gain to the United States from the elimination of this malnutrition would range from $14.4 billion to $50.3 billion. Popkin concludes that this gain would come from increased learning ability, motivation to work, productivity, physical stamina and resistance to disease; from declines in fetal, infant, child and some maternal deaths; and from the intergenerational benefits of healthier and better educated parents affecting their children.[44]

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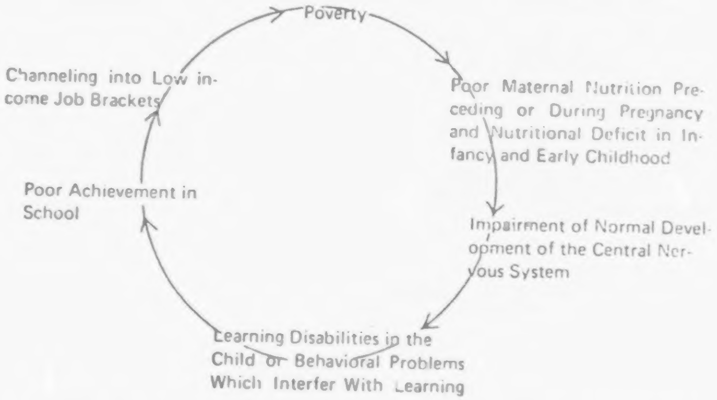
One of the most alarming implications is that poor nutrition contributes to the perpetuation of poverty, as demonstrated in the diagram below taken from the 1976 report, Nutrition in California, produced by the California Assembly Office of Research.


Poverty
Poor Maternal Nutrition Preceding or During Pregnancy and Nutritional Deficit in Infancy and Early Childhood
Impairment of Normal Development of the Central Nervous System
Learning Disabilities in the Child or Behavioral Problems Which Interfer With Learning
Poor Achievement in School
Channeling into Low income Job Brackets

Therefore, the inner city food crisis, which adversely affects the nutritional intake of the community's residents, also contributes to the economic, health and social adversities common to their everyday existence. A national preventive policy must be geared toward bringing competitively priced, nutritious foods to the inner cities rather than merely trying to eliminate the effects of undernutrition: many of the latter consequences are irreversible. The unavailability of high quality nutritious food at reasonable prices should be the right of all citizens in the United States. Denying anyone this right will be, in the end, costly to everyone.

IV.

ALTERNATIVES/CONSTRUCTIVE CHANGE

Alleviation of the food crisis confronting our cities demands fresh and coordinated approaches. No single illustrative alternative offered below is adequate to solve a problem of this magnitude and complexity. Instead, the federal government, working in conjunction with local groups, must assess the differing needs which exist and tailor solutions accordingly. In most cases, this will mean different alternatives operating simultaneously. Such variety and tenacity is essential if this problem is to be successfully tackled. Inner city communities require solutions which contain the seeds for self-sufficiency, not the all too familiar stop-gap measures which crumble the moment attention and resources are focused elsewhere. In the sections which follow, petitioners will describe some of the opportunities for constructive change which persistently lie dormant, awaiting governmental leadership, resources and coordination. Petitioners will also describe government efforts which have faltered because of sparse resources or where government has failed to take any initiative whatsoever, despite its clear mandate to do so.

A. Direct Marketing: An Efficient Link Between Farmers and Inner City Consumers

The sale of fresh fruits and vegetables directly from the farmer to consumer offers enormous potential for eliminating some of the major deficiencies of the current food distribution system. Farmers' markets inevitably benefit both the small farmer and low income consumer. Elimination of middle level processors and distributors, long distance hauling, expensive packaging and high supermarket overhead enables consumers to purchase fresh produce at prices 20-30% below those being charged at local supermarkets. In a study conducted by the University of California at Davis comparing prices at farmers' markets with those at supermarkets in the same communities, researchers found that the average unit cost at farmers' markets was 34% lower, a significant savings for those who spend more than half their incomes on necessities.[45]

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Of equal importance to inner city residents is the easy accessibility of these markets to needy residential areas. Locating the markets in neighborhoods which have been abandoned by nationwide chains eliminates the hardship of long and arduous shopping trips, which is of particular importance to those inner city residents who are elderly, handicapped or have young children. The flexibility and simplicity inherent in direct marketing makes it adaptable to a wide variety of existing local conditions; markets can be developed in vacant lots, parking lots, vacant buildings, places of worship, school grounds, city parks, and facilities can be as permanent or makeshift as desired.

Direct marketing means both fresher and cheaper food. Low prices enable families to resume eating nutritious fruits and vegetables which prohibitive costs have virtually eliminated from their diet. The elimination of four and five day delays for middle level handling means that only hours elapse between the picking and purchasing of produce, insuring high nutritional content.

Direct markets also benefit the small farmer who cannot take advantage of agribusiness' economies of scale. Small volumes may not be attractive to wholesalers, but are quite sufficient for direct marketing outlets, where the farmer can more than double his or her financial return.

The surprising irony, however, is that despite lower prices, high quality food, simplicity of distribution and ease of implementation, there are numerous obstacles to developing viable direct markets in the inner city communities. The greatest roadblocks are state regulations which restrict the farmer's ability to transport produce to the market and impose unnecessary, arbitrary restrictions on the type of produce that can be sold. For instance, while standardized container, packaging and labeling regulations serve a valid function when produce is shipped in large volume and buyers lack the opportunity to visually inspect the goods before delivery, such requirements are unnecessary in direct farmer-to-consumer transactions. Other regulations which concern the cosmetic appeal of the goods rather than their quality or safety also impede the development of farmers' markets.

A demonstration of interest in the potential of farmers' markets was shown by the federal government with the passage of the Farmer-to-Consumer Direct Marketing Act of 1975 (7 U.S.C. § 3001, et seq.), but this interest was short-lived and superficial. The USDA has failed to recognize that the legislation's purpose, to promote a method of food distribution which is "calculated to lower the cost and increase the quality of food to . . . consumers," is a particularly suitable means to help alleviate the current inner city food crisis.

Grants made to selected states to promote direct marketing were wholly inadequate, and those monies allocated generally did not benefit low income consumers. The proposals which were funded from fiscal years 1977 and 1978 appropriations neither emphasized inner city farmers' markets, nor low income consumers. Not one of the approved projects was designed to create a coordinated statewide system of markets operating in inner city communities. Kentucky was alloted one of the largest appropriations in 1978 for the implementation of a computerized model for buying and selling beef, certainly not a project of wide application, nor one of top priority for the inner city poor. By contrast, the predominantly urban state of Massachusetts received far less funding for the establishment of mobile markets, which are of particular importance to the low income elderly and handicapped. Other states, like California, with an urgent need for alternative food distribution mechanisms of any kind, were denied any funding whatsoever.

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The USDA has even failed to carry out the specific mandates of the legislation. Despite an express directive to initiate a continuing state-by-state survey of existing marketing methods, assessing their relative benefits, the Economic Research Service has never performed this important task. Many states lack the resources or expertise to do this on their own. The Science and Education Administration and the Agricultural Marketing Service reviewed the state proposals and did not fund any projects that would have produced the draft legislation needed to facilitate direct marketing, an essential step for the establishment of direct markets nationwide. In light of the tremendous potential of direct markets to reduce the severe inner city food distribution problems, it is incumbent upon the federal government to live up to the letter and the spirit of the laws already passed by a concerned Congress.

B. Food Cooperatives: Building Viable Community Control of Food Distribution

Community controlled food cooperatives offer a real alternative to the expensive, low quality food stores that currently fail to serve the needs of inner city residents. By pooling community food needs and resources, food cooperatives can significantly reduce food costs and unemployment, while developing employment skills and community pride. Low income participants, however, need meaningful technical and financial assistance to establish these cooperatives if they are to be financially secure, well managed and viable enterprises.

Simply defined, a food cooperative is a "group of neighborhood citizens who gather to buy food in bulk from wholesalers at reduced prices." Such arrangements take various forms, including networks of local buying clubs, small storefronts, mobile vans and supermarkets. Some depend on volunteer time, some do not. Whatever the ultimate form chosen, members save substantially on their food budgets. Capital costs can be minimized by using volunteer time or work for food credits; functional display areas without advertising and simpler packaging reduce costs as well. When cooperatives form networks and warehouse together, wholesale food costs are lower than those for the typical independent inner city food store. As a consequence, members of food cooperatives save anywhere from 12-40% on food items. Moreover, education programs commonly associated with cooperatives encourage economical and nutritious purchasing habits, stretching food dollars and improving poor diets.

Community based food cooperatives also provide an institutional framework for the development and utilization of local skills in many areas including management, democratic decision making and planning. Equally important is the increased community self reliance that results from organizing a successful low income food cooperative. A community controlled food store is a source of pride in the neighborhood when individuals participate in bringing about successful solutions to their most pressing problems and acquire some power over their lives.

Low income food cooperatives can be one avenue of easing the inner city food crisis. In order to establish co-ops which will sustain themselves, careful planning is needed to insure that food cooperatives are tailored to specific community needs, desires and abilities. Areas with predominantly elderly populations may require mobile markets stocked with foods that meet particular dietary needs; areas with large demand and strong community support may be able to sustain a cooperative bearing the attributes of nationwide chains -- large spaces and concomitantly large inventories, convenient locations, and long hours.

The growth and survival of such cooperatives, offering high quality food, low prices and excellent service, is dependent upon careful organization which must take the following factors into consideration:

1. A food cooperative must be solidly based in the community. If it is established by outsiders, the cooperative will not have the support necessary for success.
2. The cooperative's foundation must be financially secure. Sufficient capital for initial inventory and expenses is needed. Such money should be available in a variety of forms to meet differing community requirements and abilities.
3. Organizers of cooperatives must have direct access to the technical resources available in their own communities Access to a state- and nationwide network of individuals with particular expertise in the problems of inner city food distribution must also be facilitated.
4. To keep prices down, technical and financial assistance must be available to small cooperatives to form buying networks eligible for warehousing discounts and able to bypass middle level distributors.

Low income co-ops all over the country are making important contributions to the food distribution crisis in the inner city. Michigan's cooperative network includes many low income food cooperatives. Self-Help Action Center of Chicago (SHAC) has helped organize more then 300 food buying centers with low income inner city consumers. Through its 35 constituent co-ops, SHAC has helped over 7800 low income households save on food expenses and collectively solve community problems.

Some mechanisms for providing technical resources already exist on a national level, but they need to be directed and tailored to meet the needs of low income communities. The tremendous hope engendered by the passage of the National Consumer Cooperative Bank Act (12 U.S.C. § 3001, _et seq_.) remains substantially unfulfilled. Despite a clear legal requirement that the Board use its best efforts to insure that 35% of its outstanding loans each fiscal year are allocated to low income cooperatives, and a clear statement by the Congress that the Bank was to serve those hampered by lack of access to credit facilities, thus far the established middle class cooperatives have been the primary beneficiaries of the Act.

The Bank Act specifically included the mechanisms for low income groups to acquire much needed technical assistance. Through Subchapter II's Office of Self-Help Development and Technical Assistance, capital investment advances were to be made to low income cooperatives ineligible for loans under Subchapter I; the lower threshold for eligibility under Subchapter II meant provision of resources to the cooperatives most in need, those without a past history of financial accomplishment. Moreover, the Office was to provide information and services concerning organization, financing and management, crucial elements to a self sustaining cooperative. All this potential remained inactive for two years, awaiting a Director, precisely the period of time in which the food crisis demonstrably worsened. This legislation could be the catalyst for one of the best means of combatting the present inner city food emergency, but low income families still await the responsive leadership which will put the words into dynamic action.

C. Urban Agriculture: Planting the Seeds of Self-Sufficiency

Harvesting hundreds of pounds of fresh produce from flourishing inner city garden plots may seem foreign to those accustomed to the typically grim sight of rubble-strewn abandoned lots, but such events are beginning to occur with some frequency. Enabling community residents to grow and process their own food has proven to be a powerful means of combatting current urban food problems. By giving people the tools to help themselves, cheap and nutritious food can be obtained while community self reliance is fostered.

Whatever the form of urban agriculture -- large scale contract farming for open air markets and cooperatives, community gardening, canneries, compost projects, or solar greenhouses -- inner city families reap significant economic benefits. Figures from existing community garden projects show that by eliminating mid-level distributors, high transportation and packaging costs, and inefficient energy costs, participants stand to realize savings of $350 to $500 on their annual grocery bills. For low income consumers such savings are substantial.

The heightened availability of fresh produce through cultivation cannot satisfy all the nutritional needs of inner city consumers, but it can eliminate some of their most severe dietary deficiencies. Increased access to fresh, high quality foods could reduce illness, infant mortality and other health and social consequences of poor nutrition. Moreover, if urban agriculture is given the initial assistance required to succeed, production of other key dietary components, such as poultry and dairy products, could be attempted.

The other benefit of urban agriculture is community self sufficiency. For too long, as the Executive Director of the Center for Neighborhood Technology stated, "Low income people in general have been cut out of the system that allows them to provide for their own basic needs and leaves them with welfare as the sole alternative to starvation." Urban agriculture is a means of reversing that dependency by providing an opportunity for inner city residents to gain skills and employment necessary to meet their most urgent food needs. Successful community-based efforts such as these inevitably revitalize neighborhood pride and concomitantly, the local economy.

Unfortunately, community desire alone is insufficient to develop such ventures. Urban agriculture, if it is to be successful, requires space for cultivation, skills training in efficient methods of construction, cultivation and food processing, and assorted equipment and materials -- seeds, plants, fertilizer, and farm and carpenters' tools. Resources to meet these requirements are far beyond the capabilities of most community organizations and for this reason federal policies and programs which facilitate urban agriculture are of tremendous importance.

The space necessary and available for agricultural projects will vary with each community. The General Services Administration has the authority to conduct an immediate survey of federally-owned surplus buildings and land in targeted areas; GSA can establish space for urban agriculture as a priority in its surplus distribution scheme. Moreover, such land should be made available at cost or leased rent free to community groups. Unavailability of fertile soil or open space should not deter attempts to grow produce; the Department of Energy's responsibility to encourage appropriate technology is perfectly suited to the development of energy efficient solar greenhouses in a variety of forms within the inner city.

Equipment needs could be met in part by the Department of Agriculture. Greater efforts must be made to alert low income communities to the availability of seeds and plants through the Food Stamp Program. The Department should press for supplemental legislation allowing equipment for growing and processing food by low income residents to be purchased with food stamps, as is now the case for certain residents of Alaska. Appropriations made under the National School Lunch Program have recognized the necessity for equipment allocations to effectively implement food legislation. Equipment could also be forthcoming if the

Department of Agriculture conducted urban agriculture demonstration projects through its research divisions and through school nutrition education activities (42 U.S.C. § 1788).

Finally, technical expertise is needed to train persons in efficient gardening, construction and food processing techniques. The Cooperative Extension Service should provide bilingual personnel knowledgeable in soil testing and pest control. Through the cooperation of CETA, VISTA, Juvenile Diversionary programs and USDA's Cooperative Extensions, inner city residents could learn useful skills that would not only help eliminate the food crisis, but would also assist in increasing inner city job opportunities.

As with all the alternatives which have been previously described, the potential for urban agriculture exists: the missing ingredients are the leadership, resources and energy of this Administration focused on solving the tragic problem of inadequate food distribution in our inner cities.

D. Joint Ventures: A United Effort to Defeat the Inner City Food Crisis

Although supermarkets have found it difficult to operate in inner cities, it is not unthinkable to envision supermarket re-entry, even in the most severely impoverished neighborhoods. A variety of efforts is needed to stimulate this movement. Tax policies must be altered, government subsidies must be allocated under specified conditions, and the message must reach the food industry that food markets in cities can be profitable ventures when operators develop a heightened awareness of special community needs and desires. Re-entry as a solution is economically sound, but cooperation and commitment on the part of the large chains, communities and government is needed. Otherwise, the return of supermarkets and the opening of new, no-frills warehouse stores will be no more than a passing fad, only to depart once communities are milked dry. This tripartite cooperation -- community, private industry and government -- is more commonly known as the joint venture. Joint ventures are viable because each component contributes necessary expertise and resources according to its own capabilities, and each component benefits.

The Role Each Must Play

1. Supermarkets

The supermarket chain offers the experience necessary to establish and manage a successful food store. Too often, committed community groups, despite tremendous energy and a documented need, have floundered in their attempts to establish food stores due to inadequate training and expertise. The supermarket chain can also provide economies of scale through their existing warehouse facilities, transportation fleets, store fixtures, training programs and management personnel. All will redound to the benefit of these now isolated inner city communities.

2. Government

The federal government can be an effective force in solving the problems which caused the large supermarkets to flee the inner city. The large chain stores contend that high operating costs such as the price of land, property taxes, utility charges, insurance premiums, damage and depreciation, were the major reasons they left the inner city. To reduce these costs, the federal government can either adopt methods to partially subsidize inner city food distributors or to indirectly affect a lowering of costs.

These two alternatives can be accomplished in different ways. For example, the government could buy and develop land in the inner city, creating a package which could be leased to distributors at a cost below the fair market value. Since the property would be leased by the federal government, the government would assume occupancy expenses including property taxes, insurance, utilities and the like, thus helping to alleviate the major costs of operation.

Another possibility is the creation of "enterprise zones" located in hard hit inner city areas. In these neighborhoods, various regulations would be relaxed to spur investment, property taxes would be stabilized, and tax policies including depreciation schedules would be changed to favor food store operations. Currently there are no federal tax incentive policies to encourage business, much less supermarkets, to operate in the inner city. Instead, the government has given subsidies to businesses who chose to relocate out of the cities.[46]

The government can also provide employment training programs such as CETA and VISTA to develop the skills needed to operate and manage these large food outlets. Alternatively, the federal government could directly subsidize training programs now offered by the supermarkets. This would help alleviate high employee turnover and curtail the need to employ less experienced workers who contribute to higher operating costs.

Other possibilities include providing funding for improved security measures, insurance plans, low interest loan programs, and demonstration projects to determine the proper mix of products to best serve inner city communities. In sum, the federal government must commit dollars or tax incentive programs to encourage joint ventures. Government alone has the resources to reverse the trend of food stores abandoning the inner cities across the nation.

3. Community

The final component of the joint venture is the community, which must be involved from the beginning. Community redevelopment organizations could be particularly helpful because they can obtain the backing of local officials, other community groups, residents and businesses. A community redevelopment organization or other organization could also assist by:

- securing capital from government at low rates; since the organization would be involved in a business venture, it can assist the supermarkets in securing business loans and grants made available by the federal government to needy inner city areas;
- acquiring the zoning variances and/or public services needed to support a comprehensive redevelopment effort;
- developing short and long term goals for the venture including employment for inner city residents, and the development of satellite services such as consumer education, transportation and banking services;
- assessing the kind of food and other retail establishments required by residents;
- determining with input from food retailers if the particular establishments wanted by residents are feasible;
- conducting comprehensive evaluations of the joint venture;

The inner city residents themselves will also be central to the community's involvement. In addition to patronizing the supermarkets, residents must provide ongoing input to the community organizations which formally are part of the venture so that the residents' needs are articulated, understood and acted upon. This involvement by the community encourages a constructive business environment and mutual understanding between consumers and business.

Each Party Benefits

In order for joint ventures to succeed, each party must reap some benefit. Supermarkets will unquestionably realize reasonable profits from their participation in the venture, since the government will assist in reducing some major expenditures. The supermarket chains can also secure a reasonable management fee for their role in operating the stores, which should be over and above their share of the profits.

Communities will undoubtedly benefit from this program. In addition to a renewed local source of fresh, low cost food, the community will also realize a substantial part of the joint venture's profits. This is essential, for the community will not wholeheartedly support a program if an outside entity is the primary beneficiary. The people in the inner city have for too long felt that their communities were ruthlessly exploited by outsiders. Such feelings are not without justification. Last year Black consumers, 65% of whom live in the inner cities, spent $16.4 billion on food.[47] Nonetheless, the vast majority of this capital flowed right out of the communities where these residents live and spend their dollars, only to be invested in the development of other areas.

Moreover, a significant number of jobs will be created for community residents, particularly at the managerial levels. The community will also benefit from the education and services the markets offer.

The federal government also benefits. Since government assistance is only needed until the program becomes self sustaining, government can then shift its resources elsewhere. Moreover, as discussed in Section IV, C, supra, a preventive approach to inner city nutrition problems is far more economical than a corrective one.

The Future

While joint ventures have enjoyed only a few years of operation, they have already proven successful in Chicago. There, the Woodlawn Development Corporation works with the Hillman chain and derives its success from the strong commitment of its supporters. While joint ventures should not be viewed as a panacea for every city which faces a major food problem, they can play an important role in easing the present crisis.

V.

JURISDICTION AND RESPONDENTS

The President, his cabinet and the heads of the relevant federal agencies under the scope of Executive Order 12160 have the authority and power to respond fully to the demands of the current inner city food emergency. Their responsibilities, briefly, are as follows:

PRESIDENT CARTER, as the supreme executive officer of the nation, United States Constitution, Art. II, Sec. 1,2,3, has complete authority over the conduct of his ministerial officers who, as set forth below, have responsibilities and programs which impact directly on the problems of inner city food distribution.

Specifically, ". . . in order to alleviate shortages in foods and feeds, and to assist in stabilizing prices, the President shall carry out a program for the conservation of food and feed . . . . [T]he President is authorized through . . . the furnishing of assistance, and such other voluntary and cooperative measures as he deems necessary and appropriate, to encourage and promote the efficient utilization, care and preservation of food and feed [and] the elimination of practices which waste food and feed . . . ." Stabilization of Economy and Commodity Prices Act, 50 App. U.S.C. § 1918(a).

Under the same Act, the President has the power to delegate his authority to such "department, agencies, independent establishments, and officials of the federal government and such state, local and private agencies as he may determine." 50 App. U.S.C. § 1918(a).

There is no question but that the purposes of the legislation, ". . . to aid in curbing inflationary tendencies, to promote the orderly and equitable distribution of goods and facilities and to aid in preventing maldistribution of goods and facilities which basically affect the cost of living . . ." are particularly suited to addressing the needs of low income inner city residents who presently face a critical shortage of fresh, affordable foodstuffs.

Under the Act, if the President determines that there is no prospect that these critical shortages of commodities, jeopardizing the health or safety of the American people [see Statement of Facts, Health Consequences, Sec. IV. C, supra] may soon be remedied by an increase in the available supply without additional governmental action, he may prepare measures for conservation. "Within fifteen days after the submission of such proposed conservation measures, the Joint Economic Committee shall conduct public hearings thereon and shall make recommendations to the Congress for legislative action as in its judgment the recommendations of the President and any additional information disclosed at the public hearings may require." 50 App. U.S.C. § 1916.

RESPONDENT ESTHER PETERSON, CHAIRPERSON OF THE CONSUMER AFFAIRS COUNCIL is directed by Executive Order 12160 to formulate "such policies, definitions, procedures and standards to govern the implementation, interpretation and application" of the Order which established the Consumer Affairs Council. 1-303. The Council is directed "to provide leadership and coordination to ensure that agency consumer programs are implemented effectively," and as Chairperson Peterson has already noted, monitoring and evaluating agency consumer programs to ensure more than minimum compliance suggests "periodic analyses of the effectiveness or impact of federal consumer officers in various substantive [emphasis added] areas." F.R. Vol 45, No. 112, June 9, 1980, p. 38812. As the most critical issue facing the low income consumer today, inner city food distribution must be the number one priority in any substantive review of the current consumer affairs agenda.

RESPONDENT SECRETARY OF THE DEPARTMENT OF AGRICULTURE BOB BERGLAND has primary responsibility for food issues.

Specifically, the Secretary is directed and authorized to use all available means at his disposal to "determine the best method of processing, preparation for market, packaging, handling, transporting, storing, distributing, and marketing agricultural products." The Secretary is further empowered to "determine the costs of marketing agricultural products . . . through the various channels" and is to "foster and assist in the development and establishment of more efficient marketing methods, practices and facilities for the purpose of bringing about more efficient and orderly marketing, and reducing the price spread between the producer and consumer." 7 U.S.C. § 1622.

RESPONDENT SECRETARY MOON LANDRIEU OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT has jurisdiction over the development of our urban communities and solutions to the problems thereof; the Department is to "provide for the full and appropriate consideration at the national level, of the needs and interests of the Nation's communities and of the people who live and work in them." 42 U.S.C. § 3531. The Secretary is to advise the President with respect to federal programs relating to urban development and exercise leadership in coordinating such activities with those on the state and local levels, with a view towards encouraging comprehensive solutions to urban problems. 42 U.S.C. § 3532.

RESPONDENT SECRETARY OF COMMERCE, PHILLIP KLUTZNICK has jurisdiction over "the province . . . of said department to foster, promote and develop . . . domestic commerce." 15 U.S.C. § 1512. "Commerce" clearly includes the marketing and distribution of foodstuffs, and to this end the Secretary may, upon request of any organization, "make special studies on matters within the authority of the Department." 15 U.S.C. § 1525.

RESPONDENT SECRETARY NEIL GOLDSCHMIDT OF THE DEPARTMENT OF TRANSPORTATION has the responsibility to "provide leadership in the development of national transportation policies and programs, and make recommendations to the President and the Congress for their consideration and implementation" with "full and appropriate consideration of the needs of the public [and] users . . . " 49 U.S.C. §§ 1651 and 1653. With the Secretary of HUD, Secretary Goldschmidt has the duty to "study how federal policies and programs can assure that urban transportation systems most effectively serve both national transportation needs and comprehensively planned development of urban areas." 49 U.S.C. § 1653. The elderly and handicapped are in particularly urgent need of such transportation programs, given their current inability in gain access to decent food.

RESPONDENT SECRETARY G. WILLIAM MILLER OF THE DEPARTMENT OF THE TREASURY has responsibility to superintend the collection of revenue and consequently develop tax policy (31 U.S.C. § 1001) which has a direct and profound impact on the present structure of the food industry, and the course it will follow in the future.

As a member of the Board of Governors of the Federal Reserve Bank (12 U.S.C. § 241), as direct supervisor over the Comptroller of the Currency who sits on the Federal Deposit Insurance Corporation (FDIC) (12 U.S.C. § 1812) and as stockholder of Class A stock in the National Consumer Cooperative Bank (NCCB) (12 U.S.C. § 3014(c)), Secretary Miller has a significant role in the formulation of credit policies which are of vital importance to low income consumers.

RESPONDENT SECRETARY OF THE INTERIOR CECIL ANDRUS has the responsibility to perform "all executive duties appertaining to the surveying and sale of the public lands of the United States, or in anywise respecting such public lands . . . " 43 U.S.C. § 2.

RESPONDENT SECRETARY OF ENERGY CHARLES W. DUNCAN, JR. has chief responsibility for administering the Department of Energy whose functions include energy resource applications (42 U.S.C. § 7133(a)(1)), energy research and development 42 U.S.C. § 7133(a)(2)), consumer affairs responsibilities (42 U.S.C. § 7133(a)(7)) and energy conservation (42 U.S.C. § 7133(a)(9)). Hence, he is directly responsibile for the development of energy efficient food production and distribution, as well as for energy efficient mass transportation.

RESPONDENT SECRETARY PATRICIA ROBERTS HARRIS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES has ultimate responsibility for the maintenance and improvement of the health and social well being of Americans. (See Message of President Eisenhower, 5 App. U.S.C., Reorganization Plan No. 1 of 1953.) As such, she has the power and the duty to alleviate the health and social costs of the current food crisis. [See Statement of Facts, Health Consequences, Sec. IV C, supra.]

RESPONDENT SECRETARY OF EDUCATION, SHIRLEY HUFSTEDLER supervises all educational policies of the federal government (20 U.S.C. § 3411) including allocation of resources to vocational and adult education programs with an emphasis on consumer education and "promotion of nutritional knowledge and food use . . . to meet current societal needs." 20 U.S.C. § 2380.

RESPONDENT SECRETARY RAY MARSHALL OF THE DEPARTMENT OF LABOR has direct responsibility for the implementation of the Labor Department's functions in fostering, promoting and developing "the welfare of wage earners of the United States, to improve their working conditions, and to advance their opportunities for profitable employment." 29 U.S.C. § 551. The Secretary bears a special responsibility to provide such employment opportunities for the economically disadvantaged, unemployed and underemployed which will lead to self sufficiency. 29 U.S.C. § 801.

RESPONDENT ATTORNEY GENERAL BENJAMIN CIVILETTI as Chief Executive Officer of the Department of Justice (28 U.S.C. § 503) has direct authority over the Office of Juvenile Justice and Delinquency Prevention which has responsibility for funding and assisting diversionary programs for youth, including job training. 42 U.S.C. § 5634(8).

Further, Attorney General Civiletti has supervisory powers over the Antitrust Division of the Department of Justice which has responsibility for instituting proceedings to prevent and restrain violations of federal antitrust legislation. 15 U.S.C. § 4.

RESPONDENT RICHARD RIOS, DIRECTOR OF THE COMMUNITY SERVICES ADMINISTRATION, has chief responsibility for implementing the Economic Opportunity Program which aims to eliminate our nation's problem of poverty by opening to everyone the opportunity for education, training and work and the "opportunity to live in decency and dignity." 42 U.S.C. § 2701. Specifically, the director has direct supervision over the Community Food and Nutrition Program (42 U.S.C. § 2809) which has thus far been exercised in an ineffective manner, since it has failed to address the inner city food emergency in a substantial and coordinated manner.

RESPONDENT ROWLAND G. FREEMAN, III, ADMINISTRATOR OF THE GENERAL SERVICES ADMINISTRATION, has jurisdiction over the disposition of federal surplus property, which may then be made available to other federal agencies or private buyers.

By orienting its priorities to give greater emphasis to the needs of low income groups, the General Services Administration would be significantly helping the establishment of inner city farmers' markets, food cooperatives, joint ventures and urban agriculture.

RESPONDENT SAMUEL BROWN, DIRECTOR OF ACTION, has jurisdiction over all domestic volunteer services which are to provide assistance in the "solution of poverty and poverty-related problems and secure and exploit opportunities for self advancement by persons afflicted with such problems." 42 U.S.C. § 4951. The inner city food crisis immediately requires assistance of this nature. The Director has both the power and the duty to give this emergency the priority it deserves by assigning volunteers to projects which address this urgent problem.

RESPONDENT A. VERNON WEAVER, ADMINISTRATOR OF THE SMALL BUSINESS ADMINISTRATION, under the supervision of the President, is directed by the Small Business Act, 15 U.S.C. § 631, et seq., to "aid, counsel, assist and protect . . . the interests of small business concerns . . . with special attention to [those] located in urban . . . areas with high proportions of unemployed or low income individuals or owned by low income individuals." 15 U.S.C. § 631.

RESPONDENTS CAROL GREENWALD, PRESIDENT, AND LAWRENCE CONNELL, CHAIRMAN OF THE BOARD OF THE NATIONAL CONSUMER COOPERATIVE BANK, are charged with the responsibility of furnishing loans, financially related services and technical assistance to eligible cooperatives under the National Consumer Cooperative Bank Act, 12 U.S.C. § 3001, et seq. This legislation addresses itself specifically to the needs of low income inner city residents; the Board of Directors is mandated to "use its best efforts to insure that at the end of each fiscal year of the Bank at least 35% of its outstanding loans are to (1) cooperatives at least a majority of the members of which are low income persons, and (2) other cooperatives if the proceeds of such loans are directly applied to finance a facility, activity or service that the Board finds will be used predominently by low income persons." 12 U.S.C. § 3018(a).

VI.

RELIEF

Petitioners require both emergency and long term relief, much of which can be accomplished under existing legislative mandates, with existing resources, _if_ this Administration simply reorients its priorities, thereby demonstrating its commitment to the resolution of inner city food problems. An emergency plan must be immediately forthcoming, precisely tailored to halt the further deterioration of food distribution in the inner cities. An equally urgent need exists for stimulation of community self help efforts which can provide competitively priced quality food for those communities already abandoned, so that the conditions precipitating the current emergency will not reoccur.

Front One: Immediate Preservation Plan

In order to prevent the further deterioration of the inner city food distribution system, petitioners request that:

1. The President exercise the power granted him under the Stabilization of the Economy and Commodity Prices Act (1947) (50 App. U.S.C. § 1911, _et seq_.) and declare that there presently exists a critical shortage of food affecting our inner cities which jeopardizes the health and safety of the American people. Recognizing that the problem cannot be remedied without further governmental action, the President shall propose the following measures to the Joint Economic Committee of the Congress within 15 days:

   a. The President will determine which inner cities are most severely affected by food shortages and designate them "food crisis zones." Such determination shall take into account the proximity of existing supermarkets to the affected populous, the ratio of supermarkets to purchasers, and the accessibility of these markets to the disabled, the elderly, and to parents with young children.

b. Upon this determination the President shall ask Congress to pass immediate legislation that will:

   (1) require any supermarket within these "food crisis zones" to provide notification of the intent to close at least six months prior to the scheduled date of closure. This notification will appear prominently in the newspapers in which such stores normally advertise their goods, and will also be filed with the city's governing body and with the USDA;

   (2) require that within ninety (90) days of this announcement, the supermarket must submit an impact statement detailing the effects of the closing on the food supply to the food crisis zone residents;

   (3) require that such supermarkets provide community organizations and the city the right of first refusal on the purchase or lease of the market scheduled for closing. The federal government will immediately consult with that city and marshall all available federal assistance to enable such purchase or lease to occur.

Within 15 days after the proposed submission of these proposed measures, the Joint Economic Committee shall conduct public hearings thereon and shall make recommendations to Congress for legislative action as in its judgment the recommendations of the President and any additional information disclosed at the public hearings may require. 50 App. U.S.C. § 1916 sub(b).

Front Two: Immediately Convene a Domestic Summit Conference to Initiate the President's Inner City Food Reindustrialization Team

At the same time the President institutes measures to preserve existing inner city supermarkets, he shall convene the President's Inner City Food Reindustrialization Team, a working group mandated to implement short and long term self help solutions to the inner city food crisis. Appointments shall be made within ten working days and shall include selected representatives from inner city organizations across the nation, chief executives of the retail and wholesale food industry, selected mayors, and representatives of relevant federal departments and agencies. Such departments and agencies shall include not only those traditionally linked with foodstuffs, but also all departments key to effective self-help remedies to the inner city food crisis. (See, specifically, the Respondents named in Section V, *supra*.) Consideration shall be given, but not limited to, alternatives which have demonstrated successful results, such as direct marketing, community food cooperatives, joint ventures between community groups and private enterprise, urban agriculture and mobile markets. The President's Inner City Food Reindustrialization Team shall convene a summit conference within 10 working days of their appointment. The Team shall be headed by a person who shares the mutual respect of business, government, minorities and the elderly, and who has a track record of bold, effective action.

Further, the President shall mandate that all pertinent federal departments and agencies immediately review their programs and policies to analyze how they do or could impact on the current food crisis. This review will yield proposals for maximum utilization of existing legislation and for necessary supplemental legislation. These proposals will be turned over immediately to the President's Inner City Food Reindustrialization Team.

Finally, the Consumer Affairs Council, established by Executive Order 12160, will coordinate the continuing activites of the President's Inner City Food Reindustrialization Team with all federal agencies, to insure that this complex problem, which does not fit neatly into any single agency's jurisdiction, is solved in an integrated and expeditious manner.

CONCLUSION

In sum, Petitioners seek from the federal government assistance in launching stable, self-help solutions to the inner city food crisis, so that the current unjust conditions cannot reoccur. As the line from an old African fable says so fittingly: "Give a man a fish, he eats for a day; teach a man to fish and he eats for a lifetime."

Dated: October 23, 1980

Respectfully submitted,

Angela G. Blackwell
Angela Glover Blackwell

Lois Salisbury

On Behalf of the Petitioners

FOOTNOTES

[1] Jimmy Breslin, "A Tale of Four Women in a Harlem Supermarket," San Francisco Chronicle, March 12, 1980.

[2] Jonathan Kaufman, "The Have-Nots: Steep Inflation Means Cutbacks in Essentials for Poorest Families," Wall Street Journal, March 27, 1980, p. 1.

[3] Gene Adkins, "California's Retail Food Industry: A Breakdown of Competition," Sacramento: Assembly Office of Research, 1977, p. 1.

[4] Jim Hightower, Eat Your Heart Out (New York: Random House, 1975) p. 25.

[5] Joint Economic Committee, "The Profit and Price Performance of Leading Food Chains 1970-74", (Washington, D.C., April 12, 1977) p. 1.

[6] California Department of Consumer Affairs, "The Problems of High Costs in the Inner Cities" (Sacramento: 1977) p. 4.

[7] Jim Hightower, Eat Your Heart Out, p. 28.

[8] Gene Adkins, "California's Retail Food Industry: A Breakdown of Competition" (Sacramento: Assembly Office of Research, 1977) pp. 17-23.

[9] Community Nutrition Institute, Funding Request Department of HEW, Office of Education Consumers' Education Program, submitted May 12, 1980, p. 4.

[10] *Ibid*.

[11] J.L. Cline and J.L. Runyan, "The Food Distribution System in Washington, D.C." Testimony before the Mayor's Commission on Food, Nutrition and Health, USDA Food Distribution Research Lab, SEA Washington, D.C., August, 1978.

[12] The California Department of Consumer Affairs succinctly made the case for the food chains in its report, "The Problem of High Costs in the Inner Cities", Sacramento, 1977.

[13] Jim Hightower, Eat Your Heart Out, p. 43.

[14] *Ibid*, p. 31.

[15] California Department of Consumer Affairs, "The Problems of High Costs in the Inner Cities," p. 11.

[16] CNI, Funding Request Department of HEW, Office of Education Consumers' Education Program, Submitted May 12, 1980.

[17] Janet Clayton, "Shopping Woes: Watts' Buying Power Tied to 1st and 15th," Los Angeles Times, August 21, 1980, pp. 3, 17.

[18] 1970 Census, 1977 Special Census.

[19] 1977 Special Census

[20] I-580 on the North, Grove-Shafter on the East, and the Harbor Freeway on the South and West.

[21] Figures from Oakland Social Services Administration, 1979.

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PREPARED STATEMENT OF KAREN BERTRAM, COMMUNITY NUTRITIONIST/DIETICIAN

My name is Karen Bertram. I am a Community Nutritionist/Dietician and have worked for the last 3 years at a community health center serving low income clients, primarily Hispanics and Indochines refugees. I was active in starting a local community garden and served on the board of our local food bank. I have a longstanding interest in the issues of both domestic and international hunger. In addition to my professional memberships in the American Dietetic Association and the Society for Nutrition Education, I am active in Bread for the World and World Food Day.

I appreciate the efforts of this committee to address the problem of hunger and your willingness to formulate appropriate solutions. My comments today will focus on Nutrition Education, its importance, its availability, and the need for its inclusion in federal policy.

The reality of hunger and its consequences have been well documented by the previous speakers and by numerous studies. We respond to the problem on three levels: (1) immediate relief, (2) short term projects, and (3) long term programs. Relief programs like the local food banks and feeding programs are extremely important because they provide food, the basic means of survival. This is essential and is obviously of primary importance. However, as the well known saying regarding "giving fish" and "teaching to fish" reminds us, our federal policy must go beyond immediate relief and short term projects. We must consider the long term efficacy of federal programs, which means we must look beyond just giving food to providing both the means and the knowledge necessary to obtain an adequate diet. We must also provide Nutrition Education.

Nutrition education is the means by which the most recent research and scientific findings are translated into actual eating practices that will promote health and prevent disease in the American population. The goal of nutrition education is to affect change in eating behaviors, therefore it is more than just disseminating information or increasing knowledge. Effective nutrition education improves the food choices individuals make on a daily basis.

The history of our current federal food programs is interesting in that each program originated with, and was conceptualized as having, a nutrition education component. The food stamp legislation was based on a 1961 pilot project which had a nutrition education component. Although the legislation refers to nutrition education, it was never funded. The same is true of the National School Lunch Program. It was only in 1977, 31 years after the program began, that funds were allocated for nutrition education and training (NET).

It is also interesting to note that our most successful federal programs, in terms of documented changes in eating behaviors, are those which have nutrition education as a mandated program component. These programs, namely the Special Supplemental Food Program for Women, Infants, and Children (WIC), NET, and the Expanded Food and Nutrition Education Program (EFNEP), have documented their effectiveness in changing eating behaviors.

A recent evaluation study of EFNEP in 15 California counties demonstrated the following:

10-30 percent improvement in food safety skills, food attitudes, economical food preparation, protein consumption, menu planning, total dietary intake pattern, and a decrease in sugar consumption;

30-50 percent improvement in variety in fruit and vegetable consumption, milk consumption and total fruit and vegetable consumption;

50-70 percent improvement in nutrition knowledge, vitamin C consumption, and cooking skills;

100 percent improvement in vitamin A consumption; and

Both milk, fruit, and vegetable consumption increased to the ideal level in 50 percent of the homemakers who needed improvement.

Numerous evaluation studies of WIC have demonstrated it effective in changing eating behaviors. These studies have documented the following benefits for program participants:

Increase in weight gain during pregnancy;

Increase in birth weight;

Reduction in the anemia rates; and

Decrease in low birth weight infants, thus decreasing infant morbidity, mortality, and costly neonatal hospitalizations.

A recent evaluation of WIC, which is soon to be released, has evidently found similar results, Evaluation studies of the NET program both at the national and state levels have found that program activities have a positive impact on nutrition knowledge and food preferences of children. These studies found the following:

Increase in school lunch participation;

Decrease in plate waste in school meal programs;

Increase in nutrition knowledge among students, teachers, and food service personnel; and

Positive change in nutrition practices and attitudes toward nutrition among students, teachers and food service personnel.

In the San Francisco Bay Area nutrition education is available through various programs in addition to those previously mentioned. The attached page summarizes each program and gives a brief statement regarding the nutrition education component.

The Mayor's Task Force on Hunger Survey, to which 90 agencies have responded, included a question regarding nutrition education. It simply asked if it was provided, and if so, by whom. The results show that only 42 percent provide nutrition education and of those that do, only 30 percent have Registered Dieticians on staff. Twenty-eight percent of the agencies use nurses, physicians, or teachers who may, or may not, have adequate training in nutrition. The number of nutrition education sessions provided ranged from 2 to 432 per year.

The population in an urban area like the San Francisco Bay Area poses challenging barriers to effective nutrition education. These barriers include:

Poverty, without adequate food individuals are not interested in proper nutrition, they are interested only in survival;

Inadequate funding resulting in limited staff time inadequate materials, and insufficient staff training to implement effective nutrition education programs;

Extreme ethnic diversity resulting in language and cultural barriers. In San Francisco the ethnic minorities as a percent of total population are as follows: Chinese 12.9; Black 11.3; Italian 5.7; Filipino 5.5; Mexican 4.9; Russian 2.8; Japanese 2.1; Salvadorian 1.2; and Nicaraguan 0.9;

Insufficient culturally sensitive nutrition education materials;

Insufficient bilingual staff;

Limited outreach, individual are not aware of the prgrams that do exist; and

Lack of transportation to services and reasonably priced foods.

Based on the above information, the following are Recommendations for Federal Policy.

1. Encourage a long range planning approach to assure optimal nutritional status and health.
2. Encourage adequate funding to maintain and expand the nutrition education components of existing programs.
3. Provide adequate access to food through existing programs, but with a more timely update of the regulations, eg. the thrifty food plan.
4. Encourage creative avenues of program cooperation to maximize effectiveness of scarce resources, eg. EFNEP aides working closely with the Food Stamp Program.
5. Ensure that qualified personnel, eg. a Registered Dietician/Nutritionist, is responsible for nutrition education and staff training.
6. Provide funding for culturally appropriate nutrition education materials; and
7. Support efforts to monitor the nutritional status of the U.S. population (H.R. 4684) with specific emphasis on high risk groups.

SUMMARY OF THE NUTRITION EDUCATION SERVICES AVAILABLE IN THE SAN FRANCISCO AREA JULY 1984

POPULATION SERVED	PROGRAM	COMMENTS
YOUNG CHILDREN	Headstart	A nutritionist/dietician was recently hired, nutrition education sessions are being planned. Program serves 900 low income children.
	Children's Centers S.F. Unified Sch. Dist.	About 3000 children, 2-6 years, are enrolled. A nutritionist supervises the provision of 2 meals and 2 snacks, and a nutrition education program.
SCHOOL AGE CHILDREN	NET	The funding level has droped from 50 to 10 cents per child per year. Thus, implementation of developed programs is limited.
	National School Lunch	No nutritionist/dietician on staff with Unified School District.
ADOLESCENTS	Adolescent Program Univ. of CA, S.F.	Weight reduction and nutrition services are available through the adolescent program.
	Pregnant Teen Clinic S.F. General Hospital	Individual and group nutrition counseling is available to pregnant teenagers at the county hospital.
	TAPP: Teenage Pregnancy & Parenting Project	The National School Lunch Program provides lunch for participating teens. Two dieticians did a study and found the lunches were based on the minimum standards for grades 4-12. Lunches provided only 40% of needed calories and only 51% of needed protein.
PERINATAL	Health Center No. 4	Serves primarily the Asian population with a nutritionist/dietician providing newsletters, classes, and individual counseling. Not enough staff to adequately meet the nutrition needs of the elderly and those with chronic disease. A recent survey(Dec. 1983) of the Indochinese prenatal population found the following prior to nutrition intervention: For calories 50% were below 2/3 of the RDA; for Calcium 80% < 2/3 RDA; for iron 75% were below 2/3 of the RDA.
	WIC	Subjective comments received indicate that due to the high caseload, and limited resources, adequate nutrition education is limited.
ADULTS	S.F. General Hospital Outpatient Clinics	Individual nutrition counseling is available at the South of Market Clinic and part time at the South East Health Center.
	Food Stamp Program and the Commodity Supplemental Food Program	No nutritionist/dietician on staff, no nutrition education per se.

POPULATION SERVED	PROGRAM	COMMENTS
ADULTS (CON'T)	EFNEP	Trained staff of paraprofessionals (including Spanish speaking and Vietnamese) doing nutrition education in the homes. Eg. in Alameda Co. with a population of 276,801 families and 30,000 of those eligible to participate in EFNEP, one-half of those families have been reached in the last 15 years. The average income per family of 4 was $550.00 per month. In San Francisco it is $475.00 per month. Fourty percent of EFNEP families receive food stamps and 40% receive public assistance.
ELDERLY	National Nutrition Program for the Elderly	Nutrition education consists of a once a month session held at congregate meal sites.
	Tenderloin Senior Outreach Program	A nutritionist/dietician is providing some nutrition services through this program.

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PREPARED STATEMENT OF REV. CECIL WILLIAMS, GLIDE MEMORIAL UNITED METHODIST CHURCH

I recently returned from the Philippines where I led a delegation to observe the national elections there. What I found was poverty in its most blatant form, whether in the outlying provinces or in metropolitan Manila. There were children, young people and old people who showed the unmistakable signs of malnutrition. As we stopped at campsites of squatters we were exposed to hunger that is a microcosm of that which exists in Central America, South America, Africa and India, to name but a few locations. It is also, I can assure you, a hunger that exists in pockets of poverty here in the United States.

It is a worldwide reality, one from which this country of plenty is not free.

I am convinced that while the seriousness of malnutrition and hunger in the United States may not be as severe as in other parts of the world, still it rings true here that malnutritional diets and poverty go hand in hand. So that even while poor people in this country may not literally starve, they suffer from imbalanced diets. There are two diets in the United States—one for the haves, one for the have-nots.

At Glide we have been working to provide nutritional food to the hungry for more than 15 years. Based on that experience I can say in general terms that those who come to Glide for food fall into three basic categories.

First there are the under unemployed, or in many cases the unemployable. These are winos, alcoholics, drug abusers, the mentally disturbed, street people of all sorts—people who are gripped and caught in a system in which they are unable to break free from the vicious cycle of poverty. Many of these will never find and hold jobs. Even now, in this so called "economic recovery", there are large numbers of unemployed, underemployed and unemployable.

Secondly there are the manifestations of what has been called "the feminization of poverty", the drastic increase in poverty among women with children. We are convinced that the greatest need is now lodged with women and children. This presents a unique problem because we are talking about a systematic, bureaucratic way of responding to women as second class citizens and not talking seriously ways of helping them break out of the proverty cycle. There really is an indifference toward women of poverty. There is a paternalism, an enslaving pity, a way of seeing them solely as victims who are so victimized that little can be done except to keep them exactly where they are.

And when you begin to respond to the feminization of poverty, you see the feeding lines increase in number because these women have children to feed. And there is a corresponding increase in lines for other human services.

Finally, we have experienced a third category, which unfortunately is much smaller than the first two. There are those who finally are able to break free from the cycle of poverty, either with help from Glide or through their own initiative. But in virtually all such cases I can pledge to you that the meals they received were an important part of their breakthrough—because hunger has a way of dominating one's reality to the point where nothing else is critical. But when that hunger is addressed, other things become possible.

Hunger must be defined in the context of survival. It is the most vital and basic human need—and must be considered nothing less than that. There is a great deal of ambivalence in some quarters regarding the feeding of the hungry. Many contend that feeding programs amount only to a "handout" that contributes to a sense of dependency. We contend, however, that the "handout" mentality is grounded in the response of the feeding program—how it relates to the hungry. Further, if it were not for such feeding programs we are convinced there would be greater anger, hostility, violence, abuse and crime in our urban areas.

There are a number of things which must be considered and attempted if we are to provide effective feeding programs and, more importantly, help create social conditions under which such feeding programs are less necessary than they are now.

Most basic to the feeding of the hungry is the response of those providing the food and service. Are we concerned only with moving the hungry through our dining rooms—or are we concerned about their pride and dignity? In feeding the hungry we must include having them embrace their pride and dignity—and from that some sense of self-determination.

Secondly, we must experiment with new ways of helping people move from the food lines to the paycheck lines, from poverty to possibility. In that regard we are most proud to have been instrumental in negotiating what we consider a precedent setting arrangement with the Ramada Hotel chain whose new hotel is nearly completed a block away from this builidng. As a condition of development, Ramada has agreed to donate $50,000 a year for four years toward the development of the Tenderloin community through a fund administered by community groups. Equally as significant, Ramada has agreed to conduct priority screening of Tenderloin residents so that people from this comunity will be among the first employees hired and will constitute a substantial percentage of the work force. Therefore it is literally true that hundreds of people will move directly from the food lines at Glide Church to the paycheck lines at the new Ramada Hotel.

Similar approaches must be tried elsewhere. The private sector must be strongly encouraged to help meet the needs of the poor, particularly those who reside in their immediate area of interest.

Finally, we must be careful how we ourselves perceive programs to feed the hungry. If we consider these progarms "soup kitchens" than we will behave as though they are soup kitchens—and that is degrading in and of itself. I can tell you without qualification that Glide Church is not a soup kitchen. Rather, it is a place that serves nutritious food to those who need it—and serves it in a clean, well maintained facility whose employees and volunteers are not only mindful but supportive of the dignity and worth of those who eat here.

We do not need soup kitchens in America. What we need are soul kitchens, not in the ethnic sense but in the sense that there must be those of us who will stand with the poor, who will accept them as they are and who will help them move on.

PREPARED STATEMENT OF REV. FLOYD A. LOTITO, O.F.M., M.A., DIRECTOR, ST. ANTHONY DINING ROOM, AND CHAPLAIN, ST. ANTHONY FOUNDATION

HISTORY OF ST. ANTHONY DINING ROOM

St. Anthony Dining Room was founded by Franciscan Father Alfred Boeddeker on October 4 (Feast of St. Francis), 1950, in the heart of the City of St. Francis, San Francisco.

Fr. Alfred's concept was a sit-down dining room, a full meal, no questions, no sermons, no discrimination, but with recognition of the human dignity of each person.

There was to be no financial support by the Government or by the Church. The project was to be made possible by free will offerings of food, funds and personal services. This concept has been retained for 34 years.

Since their beginning in the 13th century, the Franciscans have always been associated with the serving of the poor. In San Francisco, Franciscans had served the poor with a breadline and/or meal tickets for many years, including 1906, the year of the earthquake and fire.

ANCILLARY SERVICES OF ST. ANTHONY FOUNDATION

Additional services for the needy have developed: a free clinic, a free employment service, a free clothing center, appropriate service programs for the elderly, especially for the poor elderly in San Francisco's Tenderloin district, through providing and delivering milk without charge or obligation, through visits, gifts of food and clothing, and a free news-bulletin with information important to the aged.

In addition, St. Anthony's now operates a dairy farm in Sonoma County with a rehabilitation program for men, a pleasant residence in San Francisco for elderly ladies on a limited income, a rehabilitation house and work program for men in the City, the Bethesda Project (a hygienic program of showers, etc, with free use of sanitary facilities adjacent to the Dining Room), Daytime "Drop-in Centers," and a Nightime Shelter for women and children.

WHO COMES TO ST. ANTHONY DINING ROOM

1. The elderly on a low fixed income, particularly those who are unable to stretch their funds sufficiently to cover food, shelter, clothing, medicine, etc, through the month. Some guests bring along jars and take out food for another meal.
2. The disabled, mentally and/or physically. Many of them have been incapable of budgeting their money. Some have no place to call home, no where to go, and are easy prey for criminals. Many become victims of violence.
3. The unemployed. Jobs are hard to find in Sna Francisco and many have been laid off from work, yet more and more people keep coming to the City looking for employment. Our Dining Room helps them to survive.
4. The completely destitute—people who receive no income whatsoever, no general aid, no social security. They are also homeless.
5. People who were beneficiaries of programs which have been cut back or cut out, such as Food Stamp programs, CETA, SSI, etc.

6. Women, children and families in distress. We are noticing more and more of them, including parents without jobs, runaway teenagers, babies with single parents.

7. Ever more numerous Hispanics from Mexico, Central and South America.

8. The hard core unemployable—mainly because of acute or chronic alcoholism or drug addiction; many are mentally or psychologically disabled, retarded, with no marketable skills, no education. Some of these people require adequate nourishment even more than others in need.

9. Possibly some abusers, people who take advantage of the free programs, and spend their own money on liquor or drugs. However, studies indicate that this is a very small percentage, maybe 2 percent.

On just a cursory survey, I learned that people come into our Dining Room from all over the United States and from many foreign countries. People being so very mobile today, it is likely that many are looking for work in various states and cities.

My own research shows that the non-poor do not mix with the poor. The non-poor would not stand in line for an hour waiting for something to eat and sit at table with the poor. Would you?

ST. ANTHONY DINING ROOM IS A SOCIO-ECONOMIC BAROMETER OF OUR SOCIETY

Over the years—and through each year—we have seen the number of guests rise and fall, reflecting economic conditions. When we first opened up in 1950, we served 150 people. Today we are averaging nearly 2200 hungry, needy men, women and children. There has been a 30 percent increase in 3 years, shown by our daily record of free meals served; our total is now over 16 million. (cf Appendix I).

In 1950, the most common profile of a guest was probably a white, elderly male. As time passed, we noticed more people of all races and backgrounds, street people, unemployed younger people, women, children.

Today, because of the economic conditions, unemployment, poverty, cut-back and cut-off of many government subsidized programs for the needy and disabled, our guests have increased noticeably.

HOW TO HELP PEOPLE

There are three levels of social help:

The first level is direct aid, giving people food, medicine, clothing, shelter.

This usually takes place in emergency conditions. When people are hungry, there's no point in telling them to wait until you get to the causes of hunger. St. Anthony Foundation does a tremendous amount of direct aid.

The second level is rehabilitation. At St. Anthony Foundation, we have rehabilitation programs available to those who are willing and ready to use them: a free employment service helping people to get jobs or teaching them how to go about getting a job, and giving them opportunity to develop skills in our St. Anthony Dining Room or St. Anthony Farm programs.

The third level is reconstruction. This includes advocacy, trying to change the structures that may cause poverty or keep people in the vicious cycle of poverty. I feel that by giving this report to you, I am now working on this level. I beg you, our civil leaders, to change the structures that cause poverty.

GOVERNMENT AND THE PRIVATE SECTOR

Both the government and private sector have to help our people. We are all "our brothers' keeper"—and our sisters' also. Government cannot and should not leave this up to the private sector.

Currently it costs us 66¢ to serve one meal. (Cf Appendix II). My experience with government programs is that it costs the government many times that amount and takes much more personnel than we have to accomplish what we do.

People complain to me about their demeaning experiences with government programs, inefficiency, bureaucracy, red tape. Some tell me they get lost in government rules and regulations, policies and procedures. Many just don't fit in to the pre-established categories.

A few people told me that Social Security cut money from them because they were eating in St. Anthony Dining Room. Social Security phoned me and asked me the cash value of each meal. Once I found out why Social Secuity wanted to know as so that they could deduct the amount from a poor person's allowance I immediately gave them the lowest figure I could.

WORLD HUNGER

We actually live in a Global Village. I believe that hunger in the United States is connected with the World Hunger problem. We in the United States comprise about 6 percent of the world's population and yet we are comsuming 35 percent of the world's resources (minerals, energy, food), while some of our brothers and sisters about the world are dying of starvation and malnutrition.

We have to simplify our lifestyle. In conscience, we cannot consume as much as we do. In many ways we are a materialistic and consumer society. This effects our brothers and sisters throughout the world.

Multi-national companies seem to determine so much of our lives, economics, the fate of the poor all over the earth. All institutions, including corporations and multi-national companies have moral responsibilities and should be accountable.

World hunger is a complex problem and I don't think there are facile solutions. Each nation can and should produce its own food. The poor in our country and in every country should have access to land and jobs so that they can feed themselves.

Throughout the world, we notice an increasing concentration of ownership of property and land in the hands of fewer and fewer people. Often landowners increase their holdings at the expense of the poor. The system is unjust. Sometimes it is held in place by an elite few who have the power, money and land and do not wish to share it.

Usually this power structure has the military behind it. The United States should not provide repressive regimes with foreign aid which helps them block the efforts of the poor and denies human rights.

I believe the poor should be empowered and enabled to share in the control of the economic resources of their country. People need land, jobs.

I see a parallel here between the poor in our land and the poor in other lands. Here we try to persuade the poor to register to vote and so enable them to become part of the decision-making that affects them, and to gain some political clout, equitable political influence. We try to get them jobs so they can enter the mainstream of society and take charge of their own lives.

In some foreign countries I see the poor striving to get land and jobs, political power, and a share in the decision-making. They too are struggling for power to take charge of their own lives through unionization of workers, establishing cooperatives and basic communities.

PEOPLE ARE OUR GREATEST ASSET

Yes, our people are our greatest asset. How we treat our needy people, the poor, disabled, elderly, unemployed, is how our country will be judged.

I think there is connection between bombs and butter. More funds and programs should be given for the development of people and not used for making wars and armaments.

So many guests come over to me and say that they want to get a job, get out of the streets, get out of poverty. Again and again I hear those familiar words: "I want to job, not a handout!"

One of the most cruel insults we can give to these people is not to acknowledge them, to say "There's no hunger problem in the United States" or to label them all "free loaders". What an erroneous stereotype!

I repeat, people are our greatest asset and this is how we will be judged.

Appendix I

St. Anthony's Dining Room

1984

No. of Days	Month	Total for Month	Daily Average for Month	Grand Total at End of Month
31	January	68,344	2,205	15,885,659
29	February	62,919	2,170	15,948,578
31	March	63,627	2,052	16,012,205
30	April	67,954	2,265	16,080,159
31	May	71,669	2,312	16,151,828
30	June	63,794	2,126	16,215,622
31	July			
31	August			
31	September			
31	October			
1	November			
30	December			

Comparison - Average Daily Number of Guests (Meals) by Years

1980 - 1,718
1981 - 1,706
1982 - 1,875
1983 - 1,923

1984 - 1st 3 Months Aver. 2,142
1st 5 Months Aver. 2,201
1st 6 Months Aver. 2,188

Monthly Average
1983 - Previous Year - by Months

January	2,029
February	1,818
March	1,877
April	1,756
May	1,810
June	1,780
July	1,786
August	1,851
September	1,938
Octiber	2,032
November	2,251
December	2,150

Monthly Average
1984 - Current Year - by Month

January	2,205
February	2,170
March	2,052
April	2,265
May	2,312
June	2,126

Appendix II

FACT SHEET - HOLIDAY SEASON 1984

St. Anthony Dining Room:

1. has noticed a dramatic increase in the number of guests in the last three years, almost a 30% increase from an average of 1700 guests a day to nearly 2200 guests a day in 1984.
2. Is called "The Miracle of Jones Street" because of the ongoing charity by donors of food, funds and services; in over 34 years, never a day's service was cancelled although it did experience a 10% drop in donations during the past year.
3. Is "The Cafeteria Without a Cash Register" and exists to provide free, hot, nourishing meals for the hungry poor, with love without restriction and every day of the year, beginning 10 a.m. and continuing ordinarily until 12:20 p.m.
4. Will serve its 35th annual free Thanksgiving dinner for the needy on November 22 and free Christmas dinner on December 25; both are delicious turkey feasts with all the trimmings, 10 a.m. until 4 p.m. in a friendly festive atmosphere.
5. Is well staffed and has many volunteers; administrative and operational costs are kept down to a low minimum; operates without financial support by City, County, State or Federal Government, or by the Church; generous people of all backgrounds cheerfully make voluntary donations to help the less fortunate survive and improve their lives.
6. Has served over 16 million free meals since October 4, 1950; usual menu: salad, meat, vegetable, potatoes, dessert (fruit or pastry), bread, butter, coffee, now averaging nearly 2200 guests daily (double that on holidays), friendly courtesy to all, no questions, no preaching, no discrimination (race, religion, etc.); our cost, usual day, 66¢ per meal.
7. Seats 240 people at a time in an attractively furnished and decorated area, 115 by 40 ft., with formica topped tables, linoleum tiled floor, acoustic ceiling, music in the air, pleasant lighting, murals of Bay area vistas, living plants; has acquired more storage and refrigeration space, more exits and a new sprinkler system.
8. Welcomes all in need, the poor, the disabled, homeless, unemployed, elderly (33% of total), victims of mishaps; serves cafeteria style to the able-bodied (they carry their trays), while waiters take food to women, children and disabled people already seated.
9. For each major holiday requires: 333 turkeys, 140 gallons of stuffing, 100 gallons of gravy, 800 lbs. potatoes, 700 pies, 100 gallons ice cream, 60 lbs. coffee, 250 loaves of bread, plus yams, vegetables, cranberry sauce, tomatoes, salad dressing, sugar, salt, milk, etc., all in the proper proportions.
10. Has a pleasant waiting room adjacent to the dining area, with sanitary facilities including well kept restrooms, showers for men and women, barber shop, laundry and delousing stall (Bethesda Project), which is especially helpful to the homeless and destitute; also information and counseling services, all available without any charge; also operates a clothing distribution center (101 Golden Gate Ave.), free clinic (55 Jones St.) and a farm for homeless men (in Sonoma County); also runs a drop-in center for all during the day and a nighttime shelter for homeless women and children.

MAILING ADRESS: Box 777, San Francisco, CA 94101
OFFICE: 121 Golden Gate Ave., S.F. 94102
TELEPHONE: (415) 552-3838

Fr. Floyd A. Lotito, O.F.M.
Director of St. Anthony Dining Room
Chaplain of St. Anthony Foundation

PREPARED STATEMENT OF LOUIE GONZALEZ, URBAN AND PUBLIC AFFAIRS MANAGER, SAN FRANCISCO DIVISION, SAFEWAY STORES

Thank you for the opportunity to speak to you today concerning food waste and Safeway programs designed to curtrail waste at distribution and retail levels.

As a leader in the supermarket industry for 58 years, we have tried to be efficient and cost effective in the handling and sale of food on our stores.

All our U.S. divisions donate unsaleable but wholesome food to local food programs and food banks where they exist. Food banks gather available food from a variety of donors and redistribute it to smaller food programs. In several cases, Safeway has been instrumental in setting up food banks in their area. In 1983, we donated more than $2 million worth of food to food banks and other food programs in the United States.

Safeway has also been instrumental in getting good samaritan laws passed in the States where we operate. These laws clear food donors of liability for the food they contribute and both food donors and recipients are in favor of them. I have attached a list of the food banks we support in the U.S.

Closer to home, Safeway is very supportive of private-public partnerships to address the issue of food waste. It provides an essential service to hundreds of thousands of people and communities where food is needed. We also promote food banks using messages on our 72 million grocery bags to convey the concept of food banking. We also lend technical assistance whenever possible to help in maintaining an efficient operation. Many food banks refer potential donors to us as references to discuss the merits of food programs and our experiences with them.

But Safeway is not the only company involved in supporting food banks and food programs.

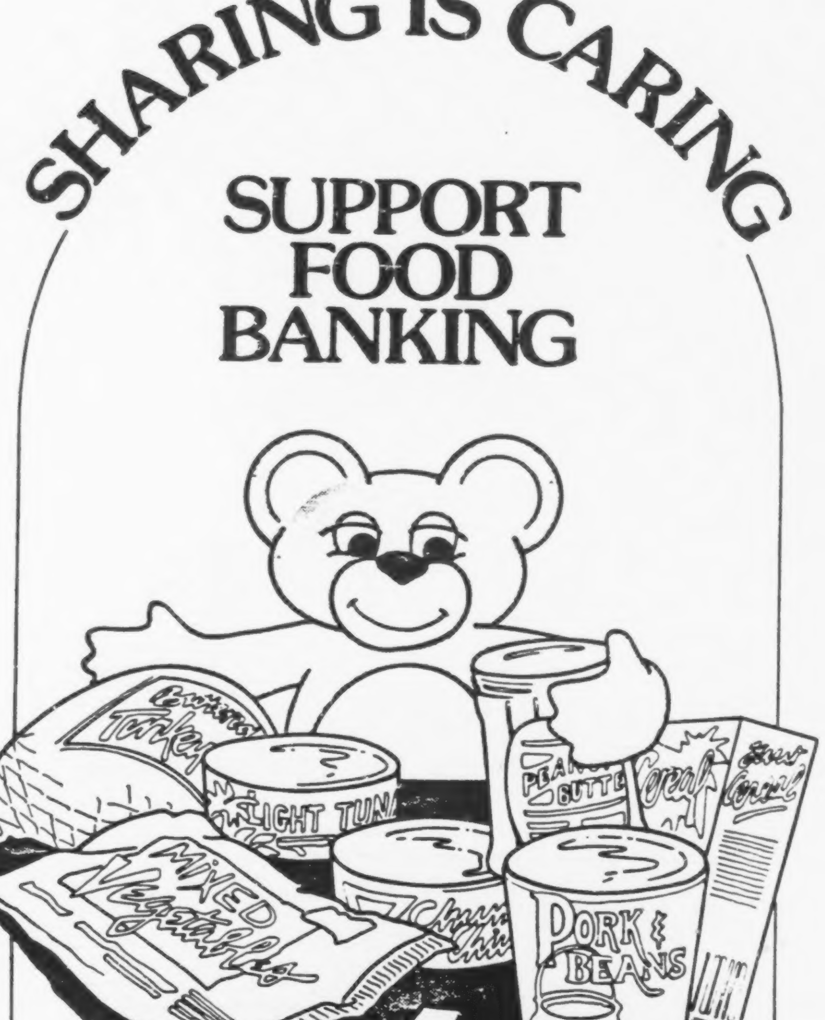
The McKesson Corporation recently awarded a $15,000 grant to the S.F. Food Bank for 1984 to help them with a refrigerated unit and a new warehouse. They have also lent technical assistance and assisted in guidance on renovation and have donated a small refrigerated truck to help in the operation. We, as members of the private sector, sit on these boards and other advisory committees of food programs to give them added experience and advise in strengthening the program.

Programs such as St. Anthony's dining room and Glide Memorial Church are excellent examples of food programs that are working. They are in the community providing food and sustenance to people who need it most.

While many of the companies I contacted to prepare to address you today are not in the food industry like a Safeway, there was an overall message that came across:

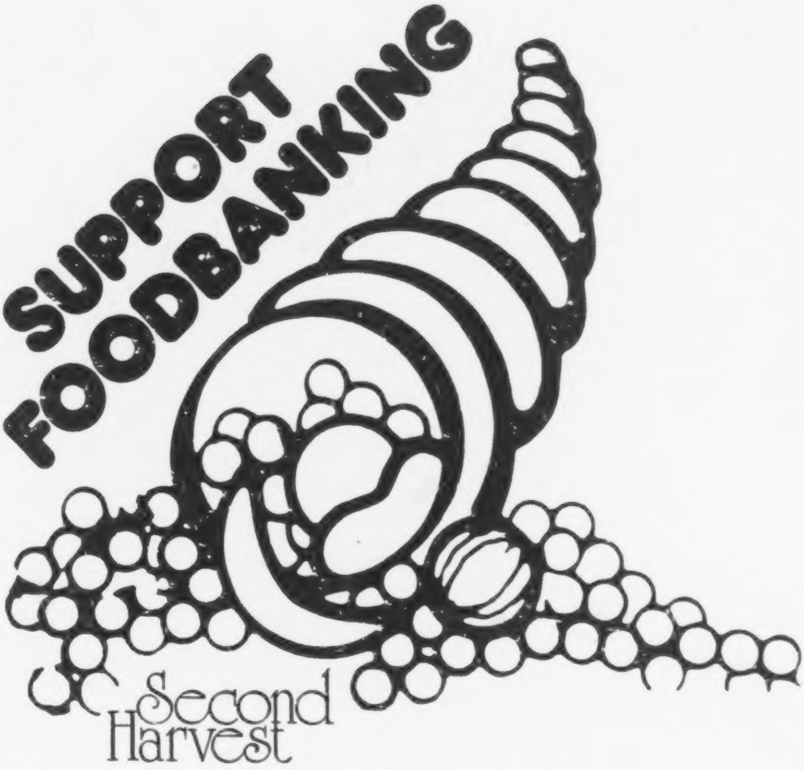
This is the best way of leveraging our resources—be it financial or merchandise—because it does cut down on wasted food in America.

Thank you.


SHARING IS CARING
SUPPORT FOOD BANKING
Turkey
LIGHT TUNA
PEANUT BUTTER
Cereal
MIXED Vegetables
Chunk Chicken
PORK & BEANS
UHT
For Information Contact:
Second Harvest
NATIONAL FOODBANK NETWORK
P.O. Box 968
Phoenix, AZ 85001
Printed Courtesy of Safeway Stores, Inc.

This Food Bank message appeared on the 72 million bags — used in one month (November 1982) in Safeway's U.S. stores.

SAFEWAY...AMERICA'S FAVORITE FOOD STORE SAFEWAY...AMERICA'S FAVORITE FOOD STORE SAFEWAY...AMERICA'S FAVORITE FOOD STORE


SUPPORT
FOODBANKING
Second
Harvest

NATIONAL FOODBANK NETWORK, P.O. Box 968, Phoenix, AZ 85001

This message appeared on Safeway's U.S. bags in October 1983

Division	Food Programs Donated To
Butte	Gallatin County Food Bank Kalispell Food Bank
Dallas	North Texas Food Bank Amarillo Food Bank Wichita Falls (TX) Food Bank Loaves & Fishes
Denver	Colorado Food Clearinghouse Pikes Peak Food Bank
El Paso	Roadrunner Food Bank (New Mexico) El Paso Interfaith Hunger Coalition
Houston	Houston/Galvestan Food Bank
Kansas City	Wichita Community Food Bank Let's Help (Topeka, KS) Central Missouri Food Bank (Columbia, MO) Harvesters (Metro K.C.)
Little Rock	No Food Bank. Division donates directly to feeding programs
Los Angeles	Community Food Resources Long Beach Food Bank Westside Food Bank Survive Food Bank Orange County Food Bank
Oklahoma City	Oklahoma City Food Bank
Phoenix	St. Mary's Food Bank El Mirage Food Bank
Portland	Tri County Interagency Oregon Food Share
Richmond	Southeastern Virginia Food Bank Central Virginia Food Bank Stanton Food Bank

Division	Food Programs Donated To
Sacramento	Fruitridge Senior Citizens
	Community Action of Butte (County)
	Sierra Community Assistance
	Senior Gleaners
	St. Vincent de Paul Society
	Salvation Army
Salt Lake City	Salt Lake Food Bank
	Community Serve
	People's Freeway
San Diego	Neighborhood House
	Yuma Community Food Bank(AZ)
San Francisco	Contra Costa Food Coalition
	Napa-Solano Food Bank
	San Francisco Food Bank
	Fort Bragg Food Bank
	Santa Clara Food Bank
	Marin County Food Coalition
	Hawaii Food Bank
Seattle	Central Area Motivation Program (CAMP)
	Auburn Food Bank
	Bellingham Food Bank
	Bothell Food Bank
	Buckley Food Bank
	Des Moines Area Food Bank
	Enumclaw Food Bank
	FISH Food Bank
	Food Oversite
	Hilltop Food Bank
	Kitsap Community Food Bank
	Lutheran Compass Center
	Monroe Food Bank
	North Tacoma Food Bank
	Pink Pantry Food Bank
	Port Townsend Food Bank
	Redmond Food Bank
	South King County Multi-Service Center
	Sunnyside Food Bank
	Valley Food Bank
	Salvation Army (13 outlets)

Division	Food Programs Donated To
Seattle(cont.)	Bellevue Food Bank
	Bonney Lake Food Bank
	Bremerton Food Bank
	Clallam County Food Bank
	Duvall Food Bank
	Federal Way Food Bank
	Food Bank of Alaska
	Fremont Food Bank
	Kent Food Bank
	Lewis County Food Bank
	Mason County Food Bank
	Northshore Multi-Service Council
	Pacific County Food Bank
	Port Angeles Food Bank
	Puyallup Food Bank
	Sequim Food Bank
	Sumner Food Bank
	Toppenish Food Bank
	White Center Food Bank
Spokane	Spokane Food Bank
	Mosses Lake Senior Citizens
	Omak/Okanogan Food Bank
	Ephrata Food Bank
	S.D.A. Community Service
	University Food Bank
	Shoshone County Food Bank (ID)
	St. Maries Community Food Bank (ID)
	Chewelah Food Bank
	Bonner County Food Bank (ID)
	Colville Food Bank
	Blue Mountain Action Council
	Valley Food Bank (ID)
	St. Vincent De Paul
	Salvation Army
	Tri City Food Bank
	Moscow/Pullman Food Bank (ID)
Tulsa	Neighbor for Neighbor
Washington D.C.	Capitol Area Community Food Bank
	Maryland Food Bank

PREPARED STATEMENT OF AMY BLOCK, ADULT EFNEP COORDINATOR, EXPANDED FOOD AND NUTRITION EDUCATION PROGRAM (EFNEP)

INTRODUCTION

My name is Amy Block. I am the Adult EFNEP Coordinator for the California Expanded Food and Nutrition Education Program. Several of the state staff were present at the hearing in California and this written testimony is presented for the record.

PROBLEM DEFINITION

The 1980 Census data has shown that there are 447,741, "poor" [1] families residing in California. This was 25 percent higher than that reported in 1970 (359,154). This 25 percent increase is 6 percent greater than explained by the increase in total families in California (1970: 5,001,224; 1980: 5,978,084; an increase of 19 percent). A research study has shown a number of nutrition-related problems in these families (California EFNEP study, 1984), including:

(1) 85 percent of families studied consumed less than half the recommended amount of milk and milk products;

(2) 90 percent of families studied consumed less than half the recommended amount of fruits and vegetables;

(3) A significant proportion of families studied had consumed large amounts of fats and sweets in their diets;

(4) Over 80 percent of the families showed limited skills in economical food buying and food preparation.

Other problems that limited the families' ability to have adequate food included:

(1) Language and communication barriers hindered use of available services:

(2) Food access problems included use of expensive neighborhood markets due to transportation problems and frequent mobility due to unemployment and high housing and utility costs, and

(3) Food stamps, if available, were not meeting the needs of the family and frequently families who received them were not able to last a month on them.

EFNEP PROGRAM—IMPACT

The California Expanded Food and Nutrition Education Program (EFNEP) has improved the dietary well-being of over 160,000 low-income families, (under the category described as 125 percent poverty level income), especially those with young children. This is about one-third of the eligible families, not correcting for the large mobility observed in low-income families.

Long range goals of the progam are to identify low-income families at nutritional risk in order to assists them in improving their diet and attaining normal nutrition. The situation, however, in reality is one in which we need to be able to respond to the immediate needs of families who are hungry. This has been done by local food banks and feeding programs.

We need also to promote a means by which all families from those acutely hungry to those at-risk of chronic and periodic hunger ensure their own nutritional adequacy. This means can best be done by educational strategies, especially those currents documented by the California EFNEP Program.

A recent evaluation of EFNEP (California EFNEP Study) has shown that:

(1) The total dietary intake improved by 17 percent, mostly due to the needed improvements made in milk and fruit and vegetable consumption.

(2) The milk consumption increased to the recommended level in 50 percent of participants who were well-below the recommended level.

(3) The consumption of fruits and vegetables increased to the recommended level in 50 percent of participants who were well-below the recommended level. Also, the variety of fruits and vegetables doubled from the selection reported before EFNEP began. The consumption of vitamin C and vitamin A improved by 40 percent and 100 percent respectively, after participants completed the EFNEP Program.

(4) Participants decreased in their consumption of fat and sugar by 20 percent.

(5) Participants improved in economical food preparation, and menu planning by 30 percent and in cooking skills by 65 percent.

(6) In a follow-up study, 3 years later repeating the same questionnaires and dietary intake studies, all of these improvements were still present, including an increase in both total food intake and in fruit and vegetable variety and consumption.

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[1] "Poor is defined as the equivalent to poverty level income.

FUTURE DIRECTION OF PROGRAM

The California EFNEP Study has shown that the one-to-one approach is very effective, and we are broadening our definition of nutrition education and including in it other ways to meet the objective of the program. The primary objective of this new approach will be to help low-income families from diverse ethnic and cultural backgrounds to improve their diets, to facilitate a community and family-based resolution to existing food and nutrition problems and to support families in achieving and maintaining these positive changes. Three new approaches are being tested in several county sites in California:

(1) New Strategies for Nutrition education: In Sonoma County we are developing a Spanish radio project to increase our impact using a cost-effective method. In Stanislaus and Kern Counties we are using volunteers to help families improve their food shopping skills. In Fresno, San Diego, San Franciso and Alameda we are targeting projects to the Indochinese refugees by assessing their needs and tailoring a program to address them. In Alameda and San Joaquin we expect to begin projects that will link with Food Stamps—how to use Food Stamps to one's best advantage.

(2) Identifying and Addressing specific food and nutrition problems not necessary related to lack of knowledge: In Sonoma, Sacramento and Santa Clara Counties we are working with local food providers to help them provide effective, nutrition meals and to organize food buying co-ops to improve and support families who cannot get transport to local supermarkets.

(3) Community Resolution of food and nutrition problems: In Tulare County we have formed a nutrition coordinating council to support local gleaning activities with local food bank services. A source directory has improved referrals and a community garden project has provided many low-income participants the opportunity to grow their own food.

These examples are just a few of the many projects California EFNEP has initiated to help in the increasing problem faced by low-income families. We expect to be linking with local agencies, community organizations and other groups to achieve an even greater impact on this pressing problem. We believe that nutrition education can do a lot more than transfer academic food and nutrition information. We think that educational opportunities have much to offer in community development and networks, in the organization of self-help groups and volunteers and in alternate food purchasing arrangements. We think that we have only begun to explore what we can do. We are committed to continuing to explore all the ways we can be helpful both in the short and long range goals of achieving nutritional adequacy for all.

SUMMARY

The California EFNEP Program has achieved success in both the traditional education of low-income families with young children and in developing new strategies to improve this impact in cost-effective ways. Most of the families we reach are the hard-to-reach, the families that are unaware of existing services. We are unique in that our contact with families is substantial and leads to change and in documented improvement. These results justify continued federal support. We are committed to helping families ensure their own nutrition adequacy both in the short and long term.

REFERENCES

Block, A.P., S. Laughlin, A. Del Tredici, C. Omelich. The California EFNEP Study. Draft Report. 1984.

Block, A.P., S. Laughlin, A. Del Tredici, C. Omelich. The Longitudinal Study: Three-year folow-up of EFNEP. Draft Report. 1984.

California Rural Legal Assistance Foundation,
Sacramento, CA, August 9, 1984.

Hon. Mickey Leland,
House Select Committee on Hunger,
Washington, DC.

Dear Congressman Leland: Jan Hartsough, from the Mayor's task force on Food and Hunger, requested that I submit the enclosed California document from AFSCME to be put in the record of the July 23rd "San Franscisco Hearing on Hunger". In addition, I would like to suggest that your committee obtain a full copy of AFSCME's report "The State, the People, and the Reagan Years" and add the analysis of social spending cuts from all 50 states to your hearing record.

This document clearly demonstrates the severity of the cuts in nutrition and other basic needs programs.

Thank you for your continued efforts on behalf of hungry people in this country.

Sincerely,

PATTI WHITNEY-WISE,
Project Director,
Food Law Unit.

the States, the People and the Reagan Years

An Analysis of Social Spending Cuts

AFSCME
in the public service

CALIFORNIA

California has lost a total of $9.5 billion in federal aid since 1981, an amount equal to $383 per person in the state. California ranks 21st out of all the states in per capital losses

Grant-in-aid losses totalled $6.5 billion, or $265 per person. California ranks 20th out of all the states in grant-in-aid losses. It ranks 2nd, however, in per person cuts in Aid to Families with Dependent Children. It also ranks 8th in losses in Child Welfare Services, and 7th in Urban Mass Transit cuts.

Losses in payments to individuals totalled $2.9 billion, or $119 per person. California ranks 27th out of all the states in per capital losses in this category.

CALIFORNIA

REAL REDUCTION IN FEDERAL AID FISCAL YEAR ESTIMATES
(BASE YEAR: FISCAL YEAR 1981)

	SHARE OF FED $	$ LOSS-THOUSANDS					$ LOSS-PER CAPITA	
	PERCENT	1982 ACTUAL	1983 ACTUAL	1984 ESTIMATE	REAGAN'S 1985 BUDGET	SUM	SUM	RANK
GRANTS-IN-AID TO STATE AND LOCAL GOVERNMENTS								
• Education								
Bilingual Education	20.09	10539	16179	17595	20192	64505	2.61	11
Educationally Deprived Children	10.19	64384	80057	77212	103877	325530	13.17	20
Education Block Grant	9.30	8158	9023	13532	-5002	25711	1.04	51
Handicapped Education	8.70	9874	7855	7830	17377	42936	1.74	46
Vocational and Adult Education	8.47	19602	16002	20479	23947	80030	3.24	52
Impact Aid	11.04	29944	33313	27807	41279	132343	5.35	21
Head Start	8.91	-2366	2463	-892	-1705	-2500	-.09	26
• Employment and Training								
Employment for Older Americans	8.17	1459	-496	1157	2997	5117	0.21	47
Employment Services and U.I. Administration	12.67	95064	126322	46447	35453	303286	12.27	15
Job Training	9.90	459573	386304	626371	686276	2158524	87.30	32
Work Incentives	13.66	14884	19709	22971	61628	119192	4.82	17
• Health Services								
Preventive Health	8.55	3749	3987	3870	4567	16173	0.65	42
Health Resources	12.51	10553	9482	10878	23643	54556	2.21	18
Health Services	7.90	20321	11002	22092	27587	81002	3.28	43
Alcohol, Drug Abuse and Mental Health	11.84	35312	38606	43641	48379	165938	6.71	20
Medicaid	10.90	135957	219409	148242	170269	673877	27.26	15
• Nutrition								
Child Nutrition	10.36	54296	17005	7971	26095	105367	4.26	21
Elderly Feeding	8.27	-208	-1360	-1537	8113	5008	0.20	45
Special Milk	9.56	12678	9238	9840	10749	42505	1.72	15
Food for Women, Infants and Children	8.29	2414	-20060	-18885	-14441	-50972	-2.05	13
• Income Maintenance and Human Services								
AFDC and Child Support Enforcement	20.62	140062	126233	278960	453954	999209	40.41	2
Community Services	9.29	16098	16841	22049	57847	112835	4.56	32
Low Income Energy Assistance	4.98	5018	-4342	-9470	4123	-4671	-.18	8
Social Services	10.44	11080	5297	23611	39550	79538	3.22	42
Child Welfare Services	13.86	14195	2374	-1914	-1035	13620	0.55	8
Special Program for the Aging	9.80	3859	4475	8099	4779	21212	0.86	31
Developmental Disabilities	7.66	403	553	755	926	2637	0.11	46
Subsidized Housing	9.77	32348	39970	35440	65891	173649	7.02	25
Juvenile Justice Assistance	12.70	6800	8958	9821	19328	44907	1.82	11
Rehabilitative Services	7.58	5483	3939	2602	10217	22241	0.90	51

Prepared by Fiscal Planning Services, Inc., Washington, DC

CALIFORNIA

REAL REDUCTION IN FEDERAL AID FISCAL YEAR ESTIMATES
(BASE YEAR: FISCAL YEAR 1981)

	SHARE OF FED $	$ LOSS-THOUSANDS					$ LOSS-PER CAPITA	
	PERCENT	1982 ACTUAL	1983 ACTUAL	1984 ESTIMATE	REAGAN'S 1985 BUDGET	SUM	SUM	RANK
GRANTS-IN-AID TO STATE AND LOCAL GOVERNMENTS								
* Infrastructure and Economic Development								
Airports	10.49	6217	-19683	-20692	-35080	-69238	-2.79	29
Appalachian Regional Programs	0.00	0	0	0	0	0	0.00	N/A
CDBG	10.05	39363	-36669	81154	101042	184890	7.48	17
Energy Conservation	3.69	12242	7254	12152	15595	47243	1.91	50
Economic Development Administration	7.38	29530	37363	30877	50090	147860	5.98	40
EPA Wastewater	8.44	232116	24386	65409	92578	414489	16.76	37
Federal Aid to Highways	7.87	64062	-176001	-221290	-208779	-542008	-21.91	5
UDAG	3.10	12169	4320	-1065	7205	21837	0.88	37
Urban Mass Transit	13.62	146411	131331	82885	163233	523860	21.19	7
** TOTAL: GRANTS-IN-AID **	11.05	1763643	1160647	1485204	2132744	6542238	264.67	20
PAYMENTS TO INDIVIDUALS								
Food Stamps	6.00	46852	-33280	47245	102778	163595	6.62	42
Medicare	11.78	66820	350160	475997	652389	1545366	62.50	9
Social Security -- Retirement and Survivors	9.26	130447	340768	319046	135167	925428	37.43	35
Social Security -- Disability Insurance	9.55	17530	41432	82716	146134	287812	11.64	27
Supplemental Security Income	12.69	11005	60728	-38761	-20993	11979	0.48	14
** TOTAL: PAYMENTS TO INDIVIDUALS **	10.14	272654	759808	886243	1015475	2934180	118.67	27
** GRAND TOTAL **	10.75	2036297	1920455	2371447	3148219	9476418	383.34	21

Prepared by Fiscal Planning Services, Inc., Washington, DC

SOCIETY FOR NUTRITION EDUCATION,
Oakland, CA, July 31, 1984.

Hon. MICKEY LELAND,
Chairman, Select Committee on Hunger,
Washington, DC.

DEAR MR. CHAIRMAN: On behalf of the Board of Directors and members of the Society for Nutrition Education (SNE) I am submitting the attached testimony for inclusion into the July 23, 1984 San Francisco field hearing testimony record.

Thank you for the opportunity to submit these comments for the record.

Sincerely,

J. MICHAEL MCKECHNIE,
Executive Director.

TESTIMONY TO BE SUBMITTED TO THE RECORD, HOUSE SELECT COMMITTEE ON HUNGER, FIELD HEARING, SAN FRANCISCO, CA, JULY 23, 1984

The Society for Nutrition Education (SNE) is a professional organization of nutrition educators whose overall goal is to promote nutritional well-being for all people through education, communication, and education-related research.

SNE appreciates the efforts of this Committee to address the problem of hunger in this country. Nutrition (and malnutrition) is a national concern and therefore, the solution to hunger and malnutrition is a national responsibility. SNE appreciates the willingness of this Committee to take on this responsibility.

Introduction

SNE has long maintained an interest in and support for federal food and nutrition programs in the belief that these programs represent an important investment in the health of the nation. Clearly, people must have the resources to purchase a nutritionally adequate diet in order to effectively use nutrition information. Additionally SNE has in the past and continues to view nutrition education as a need of all segments of the population no matter what the income level. For example, education of school age children is thought to be the most cost-efficient way in which to develop a nutritionally informed population since lifetime food habits are established at an early age. Pregnant women need nutrition information in order to eat the best diet possible for the unborn child. Nutrition education targeted towards the elderly is important in helping them cope with special diets, physical disabilities and limited incomes as well as to combat nutrition misinformation. The low-income need access to nutrition information in order to better manage their food budgets and to get the best nutrition buy for their food dollar.

It is important to note that nutrition education is not merely information dissemination, but rather the transfer of information so that it ultimately results in changes in dietary practices. In a country where six of the ten leading causes of death are linked to diet, and dental caries and iron deficiency plague much of the population, nutrition education takes on a role of increasing importance.

There are currently several federally funded food and nutrition programs that have a nutrition education component. SNE wants to emphasize the need to continue and strengthen these programs.

Nutrition Education and Training Program

The Nutrition Education and Training (NET) Program came into existence in 1977 as an amendment to the Child Nutrition Act of 1966 (Public Law 95-166), although it was not until 1979 that the program got underway in most states. The goals of the program as established by law include: (1) teaching children about nutrition and its relationship to health; (2) training school food service personnel in the principles and practices of food service management; (3) instructing teachers in sound principles of nutrition education; and (4) developing and using classroom materials and curricula. Thus, the NET Program not only teaches the concepts of food as it relates to nutrition, but actually provides a framework for putting these concepts into practice in the school cafeteria.

NET is currently operating in 54 states and territories and has reached approximately 20 million students, 700,000 teachers and 400,000 food service personnel with nutrition and nutrition education information. Additionally, many states have been able to provide information to parents, medical professionals and others who play an important role in reaching children with nutrition and health information.

Evaluation data collected from an independent evaluation funded by USDA in 1981 found that the program was functioning well and that program activities were having a positive impact on nutrition knowledge and food perferences of children. A GAO Report entitled "What Can Be Done to Improve Nutrition Education Efforts in the Schools?" (May, 1982) cited the NET Program as an effective way to implement a much needed educational program. Evaluations of the NET Program in the various states have found equally impressive results including:

Decrease in plate waste in school meal programs;

Increase in school lunch participation;

Increase in nutrition knowledge among students, teachers and food service personnel;

Positive change in nutrition practices and attitudes toward nutrition among students, teachers and food service personnel; and

Increase in parent involvement in nutrition education activities.

The funding level for NET is small compared to other food and nutrition programs. However, in spite of its small budget the program has had extensive outreach and thereby provided a large impact for a very small investment. The longer term benefits of improved health have only begun to be noticed. Unfortunately, the progress made by the NET Program thus far is threatened by the continual decrease in program funding. Over the years NET funding has decreased from $26 million in fiscal year 1978–79, to $5 million in fiscal year 1982. Thus, originally funded at a level of 50 cents per child, the program now offers only 10 cents per child per year. This decrease in funding has meant that fewer teachers, food service personnel and students are being reached with nutrition information.

An increase in funding would have a beneficial effect on the program results in increased school lunch participation the benefits of this program for the country are significant since recent studies have found that children participating in the National School Lunch Program have higher intakes of enery and other nutrients than nonparticipants. Additional funding would also enable states to pay full-time coordinators, a necessity for a strong NET Program. Permanent authorization of the program would also be beneficial in that it would greatly facilitate the continuation of on-going programs and the development of long-range plans.

Special Supplemental Food Program for Women, Infants and Children

An especially important federal assistance program is the Special Supplemental Food Program for Women, Infants and Children (WIC). This program has been shown to reduce the incidence of low birth weight infants thereby eliminating the need for costly hospitalization and medial care. It is estimated that the WIC Program is able to save up to $300 million in hospitalization costs annually.

Nutrition education is a vital part of the WIC Program. It helps the WIC recipient understand the importance of nutrition to health as well as better utilize the food package provided by WIC in order to obtain the maximum nutritional benefits possible. The law (Public Law 95–627) mandates that State agencies ensure that nutrition education is provided to all WIC participants. During each certification period, all adult participants are provided, through individual or group sessions, at least one basic nutrition education contact and, depending on need as established by the local agency, either a secondary or high risk contact. By law, not less than one-sixth of the funds expanded by each State agency for administrative costs must be used for nutrition education activities. However, because administrative money is limited, the extent to which nutrition education activities can be implemented is also limited. Therefore, SNE recommends that the overall funding for the WIC Program be increased in order that all eligible individuals can be served and also to allow for expansion of the nutrition education component of this valuable program.

Nutrition Services for the Elderly

Another important federal good assistance program is the Nutrition Services for the Elderly authorized as an amendment to the Older Americans Act of 1965. The Nutrition Services establishes two separate services—meals served in congregate settings and home-delivered meals. Studies have found that the elderly participating in the congregate and home-delivered meal services have increased nutrient intakes.

Nutrition education is currently not a required component of Nutrition Services for older Americans. However, nutrition education is particularly important for this population because older persons face a variety of problems including dietary inadequacy, declining health status, social isolation and limited access to social and health services. Therefore, SNE is pleased to see that nutrition education is mandated in the Older American legislation currently under consideration—H.R. 4785 and S. 2603. SNE encourages the members of this Committee to support the provision of a mandate of nutrition education in the pending legislation.

Expanded Food and Nutrition Education Program

The Expanded Food and Nutrition Education Program (EFNEP), an integral part of the Cooperative Extension Service, was implemented in 1968 under the Agricultural Adjustment Act to assist low-income families acquire the knowledge, skills, attitudes and changed behavior necessary for nutritionally sound diets and to contribute to their personal development and the improvement of total family diet and nutrition welfare. In 1970, the program was expanded to include low-income 4-H youth. The program employs low-income indigenous paraprofessionals who teach families individually or in small groups in their homes or in community settings to accomplish the objectives.

The program is currently operating in 54 states and territories and has enrolled over 2.1 million low-income homemakers living in either rural or urban areas and 5.5 million youth from low-income families.

EFNEP has a 16 year history of success. A Senate mandated evaluation completed by USDA in 1981 found EFNEP had improved nutrition knowledge and food behavior practices of low-income homemakers. More recently, an independent evaluation of three experimental nutrition education methods conducted by SRI International validated significant nutrition knowledge and food behavior changes occurring as a result of teaching procedures used in the EFNEP Program. Evaluations of EFNEP in the various states have found:

Better management of food resources by homemakers; for example, improved food buying decisions, and food preparation and storage skills;

Increases in nutrition knowledge among participants;

Changes in nutrition and meal planning practices by homemakers;

Better management of the food dollar by clientele including use of WIC food packages and Food Stamps;

Improvements in the nutritional quality of meals served by participating families; for example, use of less salt, fewer fried foods and more nutritious snacks; and

Improvements in program management practices such as increased efficiencies in use of paraprofessional time, use of core curriculum and targeting of resources.

An unexpected benefit of the EFNEP program has been the opportunity for personal growth of the paraprofessonal aide. For example, many have gone on to finish their GED's, others have secured better jobs while still others have gone on to college.

Unfortunately, EFNEP's ability to reach low-income families has suffered in recent years as a result of nearly level funding. This reduced purchasing power of EFNEP funds has resulted in decreased numbers of full-time paraprofessionals—3718 in 1979 down to 2987 in 1983. Not surprising, this has resulted in a decreased number of low-income families and youth being reached by EFNEP services. In 1978, 314,000 low-income families or nine percent of the families in poverty with children under 18 in the U.S. were reached by EFNEP, whereas in 1983 258,000 or six percent of poverty level families with children under 17 were reached by EFNEP. It should be noted that the 1981 Senate mandated evaluation found that states voluntarily provide an average of 50 cents for every federal dollar which is spent on EFNEP. Therefore, any cut in EFNEP funding at the federal level has a much larger impact on local programs than the reduction itself.

An increase in EFNEP funding would allow for an increase in the number of households reached as well as expanding the outreach capabilities of the program.

Nutrition Surveillance and Monitoring

Another area of interest to SNE as well as federal and state policymakers is that of nutrition surveillance and monitoring. National nutrition surveillance and monitoring data can provide information on the food and nutrition patterns and needs of the U.S. population. This information will enable nutrition and health professionals to identify populations at nutritional risk so that federal, state and local programs can be well-targeted and developed to meet actual needs.

The National Health and Nutrition Examination Survey (NHANES) and the Natonwide Food Consumption Survey (NFCS) are the primary components of current national nutrition monitoring activities. The data provided by these surveys are essential to the development of effective and appropriate nutrition education, nutrition research and food and nutrition assistance programs. However, there is a pressing need for expansion of the current system which gives inadequate attention to high-risk groups and which provides data in an untimely fashion. Thus, SNE is pleased to see that pending legislation, H.R. 4684, would put into place a coordinated system for obtaining data on the nutritional status of the U.S. population that would do much to relieve some of the problems with current nutrition monitoring activities. SNE encourages the members of the Committee to support H.R. 4684.

SNE appreciates the opportunity to express its views on the importance of both food assistance programs and nutrition education in meeing the nutritional needs of the American people and the importance of nutrition status monitoring information in serving as the foundation for a national nutrition policy.

Contra Costa County,
Family and Children's Services Advisory Committee,
Concord, CA., July 20, 1984.

Congressman Mickey Leland,
Chair, Select Congressional Committee on Hunger,
Washington, DC.

Dear Congressman Leland: Contra Costa County is the "number one" county in California, in terms of per capita income. It is also a very expensive place to live.

It is the issue of housing, and its connection with hunger, that is of major importance—not only for those who are aided by S.S.I. or A.F.D.C. (Aid to Families with Dependent Children), but for those employed in low-paying jobs.

For example: in Contra Costa there are some 4554 public housing or subsidized housing units and, currently, there is a list of over 3,000 waiting to rent these units.

Many do not even attempt to get on this long list, but try, on their own, to find the cheapest rent possible. And . . . what is possible? According to the Housing Alliance of Contra Costa, an agency set up to look for low-cost housing, the following averages prevail for cities in Central Costa County (this list is maintained using Section 8 subsidized housing guidelines); West County and East County averages are $100 lower:

	Concord	Walnut Creek	Unincorporated areas
1 bedroom	$398	$470	$416
2 bedrooms	498	578	515

The current maximum A.F.D.C. grant, for a mother with 1 child, is $448, add to this food stamps of $76 for a total income of $500—and this mother must try to find housing that stays within some reasonable ratio. Section 8 guidelines indicate a 3:1 ratio. This would mean, ideally, she must find rent for $166 a month—in an area where the low-average rent ranges from $298 in West County to $398 in Contral County.

Thus, most A.F.D.C. families in Contra Costa are forced to pay over 60 percent of their income on housing! What usually happens is that the problem of housing is translated into a problem of food. Families must cut back on food in order to have shelter—hoping, and they are usually right, that free meals are easier to come by than free shelter!

Contra Costa, we feel, is not unique in this problem of costly shelter. All areas of the state and the country have seen a dramatic rise in housing (higher in some areas than others), and shelter costs (heat, water and telephone) are squeezing the food out of the mouths of the poor.

Thank you for giving this opportunity to offer our input.

Sincerely,

Lynda Kilday,
FACSAC Chair.

[From the San Francisco Chronical, July 24, 1984]

Probers See How Malnutrition Produces Undersize Babies

(By L. A. Chung)

Six members of Congress wearing green medical smocks visited the tiny patients of an intensive care infant nursery at the University of California Medical Center yesterday.

There could have been seven, but Representative Sala Burton, D-San Francisco, said she could not bear to go into the hospital's nursery.

"It's very depressing seeing babies who just weigh a pound, especially when it can be helped," Burton said.

The representatives were all members of the House Select Committee on Hunger, which held a three-hour public hearing after paying the visit to UC's neonatal care department. The committee is under instruction to make recommendations to improve domestic and international food-related programs by November.

At the UC nursery, babies' weights are measured in grams. Some sleep in plexiglass bubbles.

Dr. Roderic Phibbs, chief of neonatology, told committee members that many of the mothers of undersize babies suffered from malnutrition during pregnancy. The babies often have lung infections and are susceptible to other medical problems.

One girl, three weeks old and less than 12 inches long, weighed only 29 ounces. It costs more than $1000 a day to care for such babies, Phibbs said, and although there are "dramatic improvements," as many as 1500 die each year in California.

"If we can generally improve the level of nutrition of a woman before and during pregnancy, we can decrease the number of low birth-weight babies," Phibbs said.

For every ounce of weight a baby gains through the mother's proper nutrition before it is born, $2000 is saved in neonatal care, Phibbs told the representatives.

Nylda Gemple, director of a federal nutritional program for pregnant women, infants and children, said there are funds for only 21 percent of the nearly 30,000 San Franciscans eligible.

Witnesses before the committee hearing at Glide Memorial Church later testified that other federal food-related programs need expansion, too. The speakers included program administrators, mid-wives, a member of the mayor's task force on hunger, food bank and church officials who urged.

Doubling the federal pregnancy/infant nutritional program budget, which currently totals $10 million in benefits in San Francisco.

Restoring the cuts made by the Reagan administration in school lunch and reduced-price lunch programs.

Alloting more funds for emergency food programs from the Federal Emergency Management Agency.

Establishing an office of nutrition in the Department of Public Health to provide nutrition education, referral and monitoring system for state and federal efforts.

Expanding the home-delivered meal program to the elderly and the disabled.

The Rev. Floyd Lotito of the St. Anthony Foundation, which feeds the hungry daily in San Francisco, told the committee: "To say there's no hunger problem in the United States is a cruel insult."